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**Legislative Assembly
of Ontario**

First Session, 38th Parliament

**Assemblée législative
de l'Ontario**

Première session, 38^e législature

**Official Report
of Debates
(Hansard)**

Monday 8 December 2003

**Journal
des débats
(Hansard)**

Lundi 8 décembre 2003

**Standing committee on
justice and social policy**

**Comité permanent de la
justice et des affaires sociales**

Organization

Organisation

Chair: Kevin Daniel Flynn
Clerk: Susan Sourial

Président : Kevin Daniel Flynn
Greffière : Susan Sourial

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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON
JUSTICE AND SOCIAL POLICY

Monday 8 December 2003

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

COMITÉ PERMANENT DE LA JUSTICE
ET DES AFFAIRES SOCIALES

Lundi 8 décembre 2003

The committee met at 1602 in committee room 1.

ELECTION OF CHAIR

Clerk of the Committee (Ms Susan Sourial): Honourable members, I think we're going to start. It's my duty to call upon you to elect a Chair. Are there any nominations?

Mr Brad Duguid (Scarborough Centre): I'm pleased to nominate Mr Kevin Flynn, the member from Oakville. Mr Flynn has been a councillor with the town of Oakville and region of Halton for over 18 years. He's been a business person for over 20 years. He's chaired numerous committees, from property tax reform, budget committees, social services to finance. I think he's very qualified, and I think he'd make an excellent Chair.

Clerk of the Committee: Any further nominations? Seeing none, I declare nominations closed and Mr Flynn the Chair.

ELECTION OF VICE-CHAIR

The Chair (Mr Kevin Daniel Flynn): Thank you very much. As the first order of business, it's my duty to call upon you to elect a Vice-Chair. Are there any nominations?

Mr Kim Craitor (Niagara Falls): I'm pleased to put forward the name of Jim Brownell.

The Chair: Any further nominations? Seeing none, there being no further nominations, I declare nominations closed and Mr Brownell elected Vice-Chair of the committee. Congratulations.

Mr Jim Brownell (Stormont-Dundas-Charlottenburgh): Thank you.

APPOINTMENT OF SUBCOMMITTEE

The Chair: Do we have any nominations for the subcommittee?

Mr Craitor: It's me again, eh? I'm pleased to move that a subcommittee on committee business be appointed to meet from time to time, at the call of the Chair or on the request of any member thereof, to consider and report to the committee on the business of the committee, and that the subcommittee be composed of the following members—the committee Chair as Chair, Mr Gravelle and Mr Klees—and that the presence of all the members of the subcommittee is necessary to constitute a meeting.

The Chair: All those in favour? Opposed? That motion is carried.

Mr Michael Gravelle (Thunder Bay-Superior North): Mr Chair, if I may, I'd like to recommend that Mr Kormos be invited to sit as a subcommittee member as well, as a non-voting member of the subcommittee.

The Chair: Mr Gravelle has moved that Mr Kormos be invited to sit on the subcommittee as a non-voting member. All those in favour? Opposed? Carried.

Is there any other business of the committee? It appears that we'll be sitting tomorrow morning at 10 o'clock, in the same room, from 10 till 12, and from either 3:30 or 4 until 6.

Ms Kathleen O. Wynne (Don Valley West): Will there be heat?

The Chair: Will there be heat? Heat's optional.

That's our business for the day. Will the members of the subcommittee please stay behind? We're adjourned.

The committee adjourned at 1607.

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STANDING COMMITTEE ON JUSTICE AND SOCIAL POLICY

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Mr Kevin Daniel Flynn (Oakville L)

Vice-Chair / Vice-Président

Mr Jim Brownell (Stormont-Dundas-Charlottenburgh L)

Mr Jim Brownell (Stormont-Dundas-Charlottenburgh L)

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Mr Frank Klees (Oak Ridges PC)

Mr Peter Kormos (Niagara Centre / -Centre ND)

Mr Richard Patten (Ottawa Centre / -Centre L)

Mr Jim Wilson (Simcoe-Grey PC)

Ms Kathleen O. Wynne (Don Valley West / -Ouest L)

Substitutions / Membres remplaçants

Mrs Donna H. Cansfield (Etobicoke Centre / -Centre L)

Mrs Julia Munro (York North / -Nord PC)

Clerk / Greffière

Ms Susan Sourial

Staff / Personnel

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Research and Information Services



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Ontario Energy Board
Amendment Act
(Electricity Pricing), 2003

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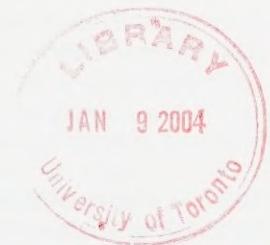
Mardi 9 décembre 2003

**Comité permanent de la
justice et des affaires sociales**

Loi de 2003 modifiant la Loi
sur la Commission de l'énergie
de l'Ontario (établissement
du coût de l'électricité)

Chair: Kevin Daniel Flynn
Clerk: Susan Sourial

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**STANDING COMMITTEE ON
JUSTICE AND SOCIAL POLICY**

Tuesday 9 December 2003

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

**COMITÉ PERMANENT DE LA JUSTICE
ET DES AFFAIRES SOCIALES**

Mardi 9 décembre 2003

The committee met at 1006 in committee room 1.

SUBCOMMITTEE REPORT

The Chair (Mr Kevin Daniel Flynn): It's a few minutes after 10. We do have representatives from two parties here, so I'm going to suggest that we start the meeting.

We've got a report of the subcommittee, dated December 8.

Ms Kathleen O. Wynne (Don Valley West): I'd like to move the report of the subcommittee before us. It's titled "Summary of Decisions made at the Subcommittee on Committee Business."

The Chair: Thank you, Kathleen. Does everybody have a copy before them? OK, you need to read it into the record.

Ms Wynne: The whole thing?

The Chair: I'm afraid so.

Ms Wynne: Your subcommittee on committee business met on Monday, December 8, 2003, and recommends the following with respect to Bill 4, An Act to amend the Ontario Energy Board Act, 1998 with respect to electricity pricing:

(1) That the committee hold one day of public hearings at Queen's Park on Tuesday, December 9, 2003, and one day of clause-by-clause consideration on Wednesday, December 10, 2003.

(2) That a notice of the committee's business be posted on the Ontario parliamentary channel and the committee's Web site.

(3) That the minister be invited to make a 15-minute presentation followed by 45 minutes of questions and answers (to be divided equally among the three parties).

(4) That members of the subcommittee provide the committee clerk with lists of who they would like to appear as witnesses.

(5) That the New Democratic Party be invited to submit the name of one organization or individual they would like to appear as a witness by 10 am on Tuesday, December 9, 2003.

(6) That witnesses (groups and individuals) be allotted 20 minutes each.

(7) That the clerk be authorized, in consultation with the Chair and the subcommittee as necessary, to schedule witnesses from the lists of names submitted by the three parties.

(8) That the committee clerk be authorized to schedule any other groups that may request to appear on a first-come, first-served basis.

(9) That the research officer prepare a summary of the testimony heard.

(10) That the parliamentary assistant, the opposition critic and the third party critic each have five minutes for opening statements at clause-by-clause.

(11) That amendments be filed with the clerk of the committee by 7 pm, Tuesday, December 9, 2003.

(12) That the committee clerk be authorized to send a copy of the subcommittee report to the NDP member of the committee.

The Chair: Any debate?

Mr Frank Klees (Oak Ridges): Unfortunately, I wasn't able to attend the subcommittee meeting that was held. The question I have is, why are we having only one day of committee hearings on a piece of legislation that is so far-reaching? It certainly affects not only an industry but every consumer in this province. Particularly in light of the commitment on the part of the government to ensure there's an open process, a new focus on democracy and giving people in this province an opportunity to air their concerns and provide input to the government of the day, I find it most interesting and most disappointing that the first piece of legislation we have in the committee is so restricted, and I'd like to know what the rationale is.

The Chair: Let's go to Kathleen and then to Caroline.

Ms Wynne: Caroline, go ahead.

Ms Caroline Di Cocco (Sarnia-Lambton): I believe it was agreed, by your party as well as ours, that we would have this length of time. There was an agreement as part of the programming motion, and therefore we have one day of hearings.

Mr Klees: Let me put it this way: You know full well that the opposition has very little say about whether it's one or two or three days. Let's be fair to the public who observe these proceedings that it's the government of the day with the majority that sets the agenda. My question isn't whether there was agreement or whether it was through the twisting of arms or whatever. My question, very simply, is that a government which throughout an entire election campaign was very clear that they intended to do the business of government differently and be very open and consultative would propose only one day of hearings on the first piece of legislation, as far-

reaching as it is. Maybe I should change my question: Who proposed the one day to which final agreement was given? Was it the government that proposed one day?

The Chair: Minister, would you like to answer that?

Hon Dwight Duncan (Minister of Energy, Government House Leader): A representative of your House leader's office proposed the two days for this bill.

Mr Klees: Two days?

Hon Mr Duncan: He agreed to it, and I believe he voted in favour of it.

Mr Klees: Let me go on record that if that was the case, I'm disappointed that the government, with its majority, didn't insist on overruling that. I certainly don't agree. I think we should—

Interjections.

Mr Klees: Well, it is. Stick around.

If I could just finish my comments, I've been a strong supporter of opening up the process. In the last number of years, members who sat with me in committee know full well the attitude I've taken in the past that I was not happy with how the business of committees was being conducted. I often argued for a more open process. I often argued for members to be given much more independence in this place, and I was hopeful that this new government would set an example, with the massive majority it has, particularly given the legislation the Attorney General introduced yesterday purporting to give that much additional empowerment to individual members of the Legislature, and this is not a good example. To try to blow this off on the opposition, as the minister has, I think is once again sidestepping an issue that he wears and that the government wears.

Mr Cameron Jackson (Burlington): As a former Chair of a committee, it's my understanding that the committee should order up its business, and I look for guidance to the Chair and to the clerk who supports this committee. I respect that in the brevity of time we have to deal with this bill, we have time for one or maybe one and a half days of public hearings. My concern is why we weren't given greater notice that the period for the hearings was to start this morning as opposed to this afternoon, and that we've not participated in the process of inviting the public here today. That would be my major concern. I accept that some latitude should be given—it's a new government and a process that's unfamiliar to all but one member of the government party present today. However, it begs the question: Have we really been able to secure sufficient people to come and present to this committee to make it a meaningful experience? Secondly, have we given sufficient notice? It's hard to believe we can have given sufficient notice to the public when my colleague and I have only recently received notice about timing and the agenda. That is a question I lay before the Chair and the clerk. I'm obviously subbed into this committee, but I suspect I'll be subbed in from time and time, and I would hope that the Chair would be able to realize that deputants are, in a loose way of saying it, negotiated. All parties bring forward suggestions.

I think it would have been a matter of courtesy to have consulted the NDP to determine if there were any individuals who they feel would be helpful to the process in terms of providing input in this public hearing. I think that would be a courtesy, and it's not an uncommon courtesy in this Parliament; from my 19 years here, it has been done quite frequently.

Again, there should be some latitude for a new government, with a new minister, with a new Chair, with a completely new committee; I understand that. But we have an experienced clerk and we have a process, and we have a long history of how we do things. The very first public hearing of this government will not be complete, nor will it be as far-reaching. Quite frankly, one scans the crowd, looking at the number of staffers here, and one can clearly determine that the public is unaware that we're having this public meeting.

So I just want that on the record. Those are my concerns. I suspect they'll be resolved under your chairmanship in future meetings, but this is not a really great start.

The Chair: Let me attempt, as the new Chair, to tell you what my perspective is on this. The issue, as I understand it, is here in the way that the House deemed it should come to us. The subcommittee meeting was held yesterday. Members of your party were here; members of the government party were here. The NDP did not attend the meeting yesterday, did not attend the organizational meeting and did not attend the subcommittee meeting to provide any input. In the absence of all that, members of the two parties, Ms Munro and Mr Gravelle, prepared a subcommittee report that's before you today. As Chair, I understand that there is perhaps a perceived shortness of time, but I think that was dealt with when the decision was made in the House.

Mr Jackson: I have taken no exception to how the House directed the committee. I was very clear in my comments not to take exception to that. I do take exception to the fact that a Chair failed to ensure that a subcommittee member of this committee should have been designated and was not. The fact that a staff member was sent was done without the knowledge of my colleague and I, and I will investigate that further as to how a clerk would order up a subcommittee meeting without an MPP present, because in my 19 years, that's never happened before. Now, I will look into that, Mr Chairman, but I would just suggest to you that in future subcommittee meetings—those are between members of this committee, and staff are not members of this committee. These are elected individuals.

The Chair: The staff member being who? I'm not following you.

Mr Jackson: Julia Kwazinski was in attendance.

The Chair: That was for your party?

Mr Jackson: The permanent members of the committee were Mr Wilson, for this committee, and Mr Klees. Neither one of those was notified to be in attendance.

The Chair: Julia Munro subbed into the committee—

Mr Jackson: Just for the subcommittee meeting.

The Chair: —for the subcommittee meeting and the organizational meeting, and agreed to what's before us here today. Obviously, I proceeded on the understanding that I had concurrence of your party that this would be—

Mr Jackson: Fair enough, Mr Chairman.

Ms Wynne: I just wanted to make the point that there are people here who want to hear the business that has been sent to us by the House. I think that if there are these internal issues that we need to deal with, they should be dealt with another time, because I think we should get on with it, given that there are members of the public here. That would be my suggestion.

The Chair: Any further debate? If not, all those in favour of the committee report? Opposed? Carried.

1020

ONTARIO ENERGY BOARD
AMENDMENT ACT (ELECTRICITY
PRICING), 2003

LOI DE 2003 MODIFIANT LA LOI
SUR LA COMMISSION DE L'ÉNERGIE
DE L'ONTARIO (ÉTABLISSEMENT
DU COÛT DE L'ÉLECTRICITÉ)

Consideration of Bill 4, An Act to amend the Ontario Energy Board Act, 1998 with respect to electricity pricing / Projet de loi 4, Loi modifiant la Loi de 1998 sur la Commission de l'énergie de l'Ontario à l'égard de l'établissement du coût de l'électricité.

The Chair: We'll move on, then, to the Minister of Energy. The Honourable Dwight Duncan will give us a presentation of approximately 15 minutes. Then there will be time equally split after the presentation for questions.

STATEMENT BY THE MINISTER

Hon Mr Duncan: With this proposed legislation, our government is taking a responsible approach to electricity pricing that better reflects the true cost of electricity. The price freeze of the former government did not reflect the true cost of electricity and has contributed to the \$5.6-billion deficit threatening this province.

The previous government changed its position on hydro privatization 11 times over the course of its mandate and finally imposed a cap at 4.3 cents. Since that cap was put in place, it has cost over \$800 million. The 4.3-cent price freeze was simply unrealistic. Ultimately, Ontario taxpayers are paying the price for this bad decision.

It would be irresponsible for the province and taxpayers to continue to subsidize electricity consumption, because this subsidy jeopardizes our ability to invest in health care and education. The days of using energy as a political football are over. We owe it to the people of Ontario to ensure that our government lives within its means and puts the public interest first.

Our plan will take the politics and politicians out of electricity pricing and give that responsibility to an

independent regulator, the Ontario Energy Board. The OEB has been directed to assume this responsibility as soon as possible and no later than May 2005. Through this plan, we are delivering on our commitment toward fiscal responsibility and fair and responsible government for the people of Ontario.

Consumer protection is an important component of our policy. Consumer protection will be the hallmark of our government's electricity policy. The proposed legislation will ensure Ontario electricity consumers have fair, predictable and stable rates that better reflect the true costs of this important commodity.

Our plan protects residential and low-volume consumers from the volatile price spikes we saw in the summer and fall of 2002, when the Conservatives were in power. Should the proposed legislation pass, we would have stable and predictable pricing so families and small businesses and other low-volume consumers can better manage their energy costs. The price would be regulated by an independent body, not by politicians. The OEB would be the price regulator and would develop a clear and transparent way of setting prices as soon as possible, and no later than prior to May 1, 2005.

Electricity prices in Ontario would be regulated on the basis of what is in the public interest. Even after the removal of the cap, electricity prices in Ontario are expected to be competitive with most nearby jurisdictions and, in fact, lower than New York, Illinois, Massachusetts and Michigan.

We are committed, through this plan, to treat consumers fairly and according to the public interest. If the interim price turns out to be higher than the true cost, all eligible consumers would receive a credit for the difference once the OEB implements their pricing mechanism.

In our plan, there's a strong incentive for conservation. Our plan includes this because it's critical to ensuring the sustainability of our supply. Conservation also makes good environmental sense because it will reduce our reliance on coal-fired generators, which will help us meet our commitment to phase out coal-fired generation by 2007. The fact that consumers have been shielded from the true cost of electricity has encouraged consumption instead of encouraging conservation.

Starting April 1, 2004, the first 750 kilowatt hours consumed in any month would be priced at 4.7 cents per kilowatt hour. Consumption above that level would be priced a higher rate of 5.5 cents per kilowatt hour. A typical suburban home in Ontario consumes approximately 1,000 kilowatt hours per month. Conservation measures could help reduce that consumption level. Since the proposed plan would not take effect until April 1, consumers would have a chance to review their energy use, take conservation measures and, as a result, limit the impact of the price change on their personal bills.

We will be reinforcing our message about conservation in many ways. For example, the government will be taking action to improve its own conservation performance. In the coming weeks, the Chair of Management Board will be announcing a new plan to make a notic-

eable reduction in the government's overall energy consumption. The Minister of Finance recently announced that the current provincial sales tax rebate for energy-efficient appliances would be extended in order to encourage and support energy efficiency and conservation.

We will also expand efforts to educate consumers about steps they can take to conserve electricity and use other forms of energy with information designed for households and businesses. To ensure our energy future, the Ministry of Energy and the Ministry of Education will work together to build conservation awareness in the curriculum for kids in school.

As of March 2005, local distribution companies would be allowed to achieve their full commercial return, but only on condition they reinvest the equivalent of one year's worth of these additional monies in conservation and demand-management programs. This represents an investment in new conservation initiatives of approximately \$225 million, one of the largest investments in conservation of its kind in Ontario's history.

As citizens of this province, we all have a responsibility to conserve energy and protect our environment.

Our government's plan promotes a safe, reliable and sustainable supply of energy for the future. This plan is a major step toward attracting new electricity supply to Ontario and to sustain our future needs. We're sending a clear signal that Ontario intends to deal with electricity issues in a practical, sensible and transparent way.

The former government didn't create any new supply in their years in office. Because of the failure to keep Pickering properly maintained, the former government was forced to take 4,600 megawatts of nuclear power offline in 1997. These problems are now expected to cost us \$3 billion and have put Pickering A years behind schedule. Supply shortages have been the result of this.

This bill and our plan reaffirm our commitment to modernize our electricity system by attracting new supply, encouraging conservation and delivering cleaner energy to the people of Ontario.

Finally, I found it almost laughable that the official opposition, a party that did not send one bill to committee in the last year of its mandate, is sitting here complaining. The member Mr Klees voted in favour every time on time allocation. I'm astounded they didn't realize they had a member at the subcommittee—I was certainly aware of that—and that that member agreed, not only to this process but to the delegations that are here and was invited to provide names.

The final point that needs to be made is that, again, it's almost laughable, but this bill was subject to agreement in terms of the number of days of committee hearings, the delegations, and that party voted in favour of it. Coming from a group that did their budget at Magna instead of the Legislature, to lecture us using a new parliamentary tool, which both the government and the official opposition agreed to, is almost laughable.

Your record, Mr Klees, I would suggest, is the worst in the history of this province when it comes to democracy. I would like to have a lot more hearings on this

bill. I think everybody would. We have to get on with this. We're providing third reading debate, something your government never did using time allocation—never. And when it did, it was limited usually to 20 minutes. We've got third reading debate here. Last night something happened in the Legislature. Not many of your members were there when this happened, but I'll relay it to you.

Mr Jackson: On a point of order, Mr Chairman: The Minister, in his zeal—it's unparliamentary to discuss attendance. He knows that. If he'd like me to put on the record those members of his government who were not in attendance last night, I'd be pleased to do that.

Hon Mr Duncan: I withdraw that, Mr Chairman.

Mr Jackson: It's not appropriate, nor is it necessary.

The Chair: It's been withdrawn.

Hon Mr Duncan: Absolutely right. I shouldn't have said that. What happened last night was that for the first time in eight years a minister was able to do a reply to his bill. Why has that never happened before in the last eight years? Because the previous government used time allocation.

Let me put it in context for you. The previous government used time allocation on almost 95% of its bills. The closest to that, prior to that government, the Harris-Eves government, was the Bob Rae government, which used it on about 6% of its bills, and the David Peterson government, which used it on about 3% of its bills overall. The previous government sent budget bills to time allocation with no committee. The previous government sent budget bills with no third reading debate.

We think this new programming motion, which the member's party agreed to, supported, negotiated, sat down with, agreed to the number of days of hearings, is a very good way of proceeding in the future. It was a pilot project, and we're hoping this can be done in more cases in the future. As I say, my understanding coming in here was that Ms Munro participated in the subcommittee and that everything brought forward was agreed to.

With that, I've used, I think, 10 of my 15 minutes. I'll be happy to take questions for 50 minutes on whatever issues you choose to raise. This is an important step forward, in our view. We think it's important. It will help address the deficit. It will help address conservation. We think it's a giant step forward in making sure we have a safe, reliable, sustainable supply of energy in Ontario's future.

One other thing: In eight years as a member of committees here, very few bills got to them. I don't remember once a minister coming to committee to open it up.

1030

The Chair: We intend to hear from the public, beginning at 11 o'clock this morning, so we've got about half an hour left. The intent was to divide the question time between the three parties; however, we only have representatives of two parties here.

Mr Klees: I thought there were only two parties.

The Chair: Mr Kormos is not here, would probably be the better way of putting it. Mr Kormos was to be

allocated an even share of the question period time. I'm going to suggest that for the time being we just divide that in two, which would leave us approximately 15 minutes for each party, if the opposition would like to start.

Mr Jackson: Minister, could we go over some of the increased cost factors that were contained in your report? Specifically, I want to inquire further about the LDCs. Your narrative in the House indicated, as of March 1, 2004, there would be deferred asset recovery in the amount of \$750 million that LDCs would be allowed to charge back. These are pre-approvals from the Ontario Energy Board, correct?

Hon Mr Duncan: That's correct. Is it 2004 or 2005?

Mr Jackson: There are two tranches of LDC—

Hon Mr Duncan: It's 2004 for the first tranche, yes.

Mr Jackson: So there are two tranches here. The first one is the \$750 million over four years. Will the OEB be allowed to accept new applications in the next four years under your bill?

Hon Mr Duncan: New applications for?

Mr Jackson: From the LDCs for further cost recovery.

Hon Mr Duncan: That provision is not provided in this bill, but we will be coming forward with that as part of the regulation under the bill.

Mr Jackson: Allowing them to do that?

Hon Mr Duncan: Rosalyn, do you want to join in here just to make sure I don't give the wrong information?

The Chair: Could you identify yourself for Hansard, please.

Ms Rosalyn Lawrence: My name is Rosalyn Lawrence. I'm the director of the consumer and regulatory affairs branch.

Under Bill 4, there are provisions that will remain in place until they are repealed that will require utilities to seek prior written approval of the Minister of Energy before proceeding to the board with rate applications.

Hon Mr Duncan: That's until such time as the board—

Ms Lawrence: Until they're repealed.

Hon Mr Duncan: Yes, exactly.

Mr Jackson: I'm still seeking an answer to my question. Can an LDC in the next four years make a further application to the OEB for a recoverable?

Hon Mr Duncan: Yes.

Mr Jackson: OK. So now there's the potential for three or four increases for an LDC in the province over the next—there's the \$750 million, which is the cost recoverables already approved by the OEB. The second tranche of money that consumers who now have to—is the return on investment, the guarantee that they can make 9.8% profit, even though they're owned by most municipalities. That will generate a further \$220 million. Is that correct, or does that \$220 million represent the one quarter?

Ms Lawrence: The third tranche of the return on equity is estimated to be about \$225 million across the sector.

Mr Jackson: That's almost a billion dollars that consumers will have to pay. What's the—

Hon Mr Duncan: I think it needs to be said that consumers are paying that now. Number one—

Mr Jackson: Could I finish my questions, Mr Chair, and then the minister can respond?

The return on investment: The incremental revenue is \$220 million. This is a not a one-time, whereas the deferred recoveries of \$750 million are one-time. They just spread that over four years. We've established now that the distribution companies can then go in and make applications on top that could, in theory, be an equivalent amount. But I'm not going to speculate on that.

At the end of that pay-down period, that ceases and then there's another round of recoverables that then have to be—it's not like rent control where it becomes the base and you just keep paying at that base each year; is that correct?

Ms Lawrence: The utilities will have variance accounts, as do the gas distributors currently, and they will—

Mr Jackson: I'm not talking about gas distributors; I'm talking about the LDCs, the local distribution companies: Burlington Hydro, Toronto Hydro. They are recoverables. When they invest money into their infrastructure, they get to reclaim it. On top of their recoverables, they get their profit margins. Those two combined are \$1 billion for consumers.

What I wanted to establish is that it's possible for an LDC to begin another rate application during this period. So in no way are you freezing, or protecting consumers from further applications. In other words, will there be a period of stability? You're completely opening up the recoverable rate applications to all distribution companies across the province. I call them companies; they're mostly municipal.

Hon Mr Duncan: Under this regime, I have prior approval of that until such time as the OEB takes over.

The second point I wanted to respond to is that the consumer is paying for those charges anyway. They're landing on the balance sheet of these LDCs, which is again why I suspect AMO, the Consumers' Association of Canada and others have supported this bill.

Mr Jackson: Are you investigating, for example, that LDCs are engaged in allied businesses but not necessarily direct businesses in the delivery of hydroelectricity and power to people's residences and that they are blending those into their—I'm trying to determine a degree of consumer protection in your regulatory framework, which is not before us, which is understandable. I don't expect you to have the regs ready, but at some point we would like to see the regs before they go.

Hon Mr Duncan: That's a valid concern, number one. Number two, this bill does not address that; you're absolutely right. Number three, we will be looking at all of those issues once we're through this. I should say that the structure we have set in the interim, until such time as the OEB comes up with a reg, we believe affords a much greater degree of consumer protection in the context of a

price that better reflects the market price of producing electricity than has been present certainly since the cap was imposed retroactively last November.

Mr Jackson: I understand the mantra that you're presenting. Not once throughout this process, since the day you tabled it in the House, have you talked about the mitigation strategy. You've brought staff here today who can address some of the issues of the mitigation fund, because with new energy coming on stream—

Hon Mr Duncan: Sorry, what do you mean by the mitigation fund?

Mr Jackson: You have indicated, according to the comments of your consultant, Erik Peters, that we're going to show an \$800-million loss this year. When our government brought in the legislation for consumer protection that placed the cap differently from where you're going to place the cap—

Hon Mr Duncan: Eight hundred million is the net figure?

Mr Jackson: Yes.

Hon Mr Duncan: You're referring to the mitigation figure on OPG's books, correct?

Mr Jackson: That is correct.

Hon Mr Duncan: OK. That's not dealt with in this legislation.

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Mr Jackson: I know it's not, but the reason this legislation is before us is because you're suggesting it's in the consumers' best interests to pay a rate that is much higher. We're suggesting that the mitigation strategy was always going to be, at the front end, very costly, and at the tail end, by 2006, it would be revenue-neutral as new supply comes on. That was confirmed by your staff yesterday in our briefings: that there are some 2,000 extra megawatts of power on stream now that have had a chilling effect on price. As more supply comes on the market, we will move that price progressively lower.

It strikes me that there's been no effort to look at the projections. My understanding and information is that there was a net profit made, that there was less in the month of October and that in fact there was not a net loss in the mitigation strategy, that it had reached a position of revenue neutrality. So it would be misleading in the extreme to suggest that each and every year between now and 2006 it's going to cost us \$800 million. That's my point.

Hon Mr Duncan: No, and what we said was, for the balance of this year, it would have been about an additional \$240 million. Projections that we had said it could have cost a total of another \$1.6 billion to \$2.4 billion depending on the market price; you're right about that.

There is not a credible analyst who suggests that by 2006 this thing would not be adding to the provincial deficit, either our finance ministry and the Ministry of Energy or by the former Provincial Auditor, Mr Peters.

Mr Jackson: I asked that question of your staff, which used to be our staff.

Hon Mr Duncan: They said that was your plan. The problem is, your plan wouldn't have worked.

Mr Jackson: Those numbers were generated by the Ministry of Energy.

Hon Mr Duncan: Your plan wasn't going to work. That's why we had to get rid of it.

Mr Jackson: That's fair enough when you say that. I am simply suggesting that the plan was developed and the numbers were crunched out by the Ministry of Energy, and—

Hon Mr Duncan: We would submit—

Mr Jackson: —if I may finish—there is evidence in the month of October of its revenue neutrality. That's what I'm saying—as more supply comes on board. If we take the microscope up and we can agree that caps are inherently wrong, if you embrace that principle, you've simply moved the cap.

Hon Mr Duncan: In the interim, yes, we have.

Mr Jackson: In very simple terms—

Hon Mr Duncan: And that is the major consumer protection piece in this.

Mr Jackson: I don't want this to be a debate. I'd like to raise a question.

The Chair: Let the minister answer the question.

Hon Mr Duncan: I've been listening intently—

Mr Jackson: I haven't asked a question yet.

Hon Mr Duncan: Yes, you did.

Mr Jackson: I was proposing—

The Chair: Answer the question. It's your time, obviously, but I heard a question. If you'd like to answer it—

Hon Mr Duncan: I'll try to keep it brief. Your government's numbers simply had no credibility. There's not an independent analyst who agrees with them. That's number one.

Number two: Yes, there is an interim price until such time as the OEB can come up with the regulation and implement it. This government decided that, recognizing that we have to better reflect the cost of energy, we need to give consumers a period of time, which will expire no later than May 2005, to prepare—unlike what you did to them, when you sent them to the spot market in the spring of 2002, which forced your government to abandon its entire policy and then move to a cap price. We think this does afford an element of predictability, number one. Number two, you raise a very valid concern, and I share that: market price as well. There are projections that say market price is going down this year. However, as I think your government learned the hard way, these predictions are notoriously inaccurate. So we've erred on the side of caution.

I need to point out two things. If by chance the price we set is higher than the market, consumers will be credited back on their bills. If it turns out to be lower than the market, then the OEFC will eat whatever the difference is. So I think we've put in very good protections for consumers, giving them a time to adjust to the new pricing regime that the OEB will come up with.

Mr Jackson: I think we've established—

The Chair: You've got about two minutes left, just so you know.

Mr Jackson: Minister, yesterday your staff indicated that the OEB may contract out their responsibilities in accordance with your direction. That's the first time we've heard that. Could you share with us under what circumstances you might consider who this group might be?

Hon Mr Duncan: They said, "if that's the direction." I can tell you, we haven't even begun to discuss those issues at this point.

Mr Jackson: I've got several more questions. One of the reasons that we proposed 2006 for the cap to come off was that it would give consumers sufficient time to modify their metering requirements, because the technology hasn't caught up with consumer demand, and consumer demand is going to increase rather rapidly under the fact that they're going to pay more for hydro under your plan. Therefore, the ability to deliver the discount on 750 versus the 1,000 in terms of the rate break doesn't help people in a variety of circumstances.

I'll give you an example: an apartment building with 200 units that doesn't have individual metering in each individual apartment. Can we find a way and can we secure in regulation the protection that they'll get the 750 break to the higher break in all circumstances?

Hon Mr Duncan: Yes, we can do that.

Mr Jackson: Then can we agree that we will do that in retirement homes?

Hon Mr Duncan: Can I get back to you on that? I'd like that to be the case. I think you raise a valid concern. Let me get back to you on that.

Mr Jackson: Thirdly, even though it's the government paying, it is the not-for-profit sector who have about 30% of the Ontario market for nursing homes. Would they as well apply?

Hon Mr Duncan: I will undertake to get back to you on that.

Mr Jackson: I have rather extensive lists.

Hon Mr Duncan: Well, the bottom line is—

Mr Jackson: Let me finish: student dormitories in universities, a whole host of locations. I would like to ensure that the regulations will cover and protect these individuals so that they get this minimal break, but it's a substantive break when you multiply it times 200 units.

Hon Mr Duncan: Many of these are already designated, I've just been told by my officials, and already covered. If you'd like to give us that list—and I should point out, Chair, one thing I did forget to make note of. The critic for the official opposition did ask to have the opportunity to be briefed by my officials in the lead-up to this. We were very delighted to provide that. That was never offered to us when we were in opposition. I did want to make that point.

Mr Jackson: I was a minister. Mr Klees was a minister. Not only—

The Chair: Your time has expired.

Mr Jackson: On a point of order, Mr Chairman: The minister is being quite unparliamentary here. We've

tolerated a fair bit of it, but I'm not going to sit here and get a lecture from him when routinely not only did we provide briefings well in advance—you shake your head. You weren't my critic. I just think—

The Chair: Your point is made.

Mr Jackson: —it's a little boorish and it's a little inappropriate and I think we shouldn't be rewriting history here.

The Chair: Would you like the minister to withdraw his remark?

Mr Jackson: Yesterday, the minister couldn't even deliver the material. We couldn't even begin the comments in the House because he didn't deliver the material on time.

Hon Mr Duncan: It turns out it was in the desk.

Mr Jackson: That's a fabrication.

The Chair: Order.

Mr Jackson: Dwight, get some class.

The Chair: Cam, I'm new in the chair. I could use your assistance; I really could.

Mr Jackson: I apologize.

The Chair: Thank you.

Are there any members from the Liberal side, the government party, that have questions for the minister?

Mr Brad Duguid (Scarborough Centre): Just a couple of questions.

Minister, you mentioned the need for this bill from a conservation perspective, with regard to preserving supply and the environmental benefits, and I think both of those are very real. But from a financial perspective, you didn't talk too much about the need for moving forward with this initiative in a rapid manner. Would you outline the impetus for this bill from that perspective?

Hon Mr Duncan: The net cost of the cap is at \$800 million for the first year. Our concern was that, going forward, that couldn't be sustained. It contributed to the \$5.6-billion deficit that the Conservative government left. We felt that in the context of health care and education, most Ontarians would believe they should be paying the market price for their electricity. I think most people understand that nothing comes free. Ontarians were in fact paying for the cap through their taxes. Not only that, but with the previous government's deficit, that money was being put on to the province's books, borrowed and added to the province's debt, and we're paying interest on it.

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What we've tried to achieve is a pricing mechanism in the interim that will allow consumers to make relatively modest adjustments to their consumption that will help them absorb whatever increase they're potentially faced with, recognizing that if we don't do this, it will compromise the province's ability to move forward in other important areas like health care, education and the environment. This year alone, we would have added \$200 million to the debt. Projections range, again depending on what the eventual average market price of electricity would be, between \$2 billion and \$4 billion by the end of 2006, when the cap was originally supposed to come off.

Mr Duguid: You mentioned as well when you were speaking that the OEB will be the price regulator rather than politicians. Could you maybe expand as to why there's an advantage to having that?

Hon Mr Duncan: Most potential new energy suppliers have told me that the regulatory environment under the previous government was completely unstable and that, in effect, they said one thing and did another. For instance, in Sarnia—I see the member for Sarnia here—there's a new TransAlta gas plant coming on stream. Nobody is willing to make investments when governments come in and artificially set the price, because obviously the ability to make an investment is contingent upon a future stream of revenues, and if governments of whatever stripe show a desire to artificially influence that, it causes great nervousness from the investor's perspective. But more interestingly, the big banks have told us that they won't backstop financing on anything in Ontario because of the nature of the previous government's flip-flops on their energy policy.

We're trying to create a stable environment, because we do believe there's a role for private generation in Ontario selling into a public system. There has been virtually nothing done in the last five years with the problems we've confronted in our nuclear system and elsewhere. It's important to create an environment where both banks and potential private producers feel there's a stable regulatory climate in order to make the kinds of investments—these things have, as I understand it, a long-term payback. There's a high up-front capital cost and the payback doesn't come for quite some time down the road. The price cap was harming our ability to generate new supply.

Mr Duguid: Given the information we received last week regarding Pickering, the financial picture to me is even more dramatic than it would have been in the past. How does the information we received last week impact on the need to get this bill through?

Hon Mr Duncan: They're separate but related issues. Number one, Pickering really addresses the larger question about OPG in the future, the future of nuclear and what we call our balanced portfolio of energy sources. This bill is only a first step in terms of ensuring a long-term supply. If this cap is allowed to stay on—and I've met with most of the large private generators in the province—there's no incentive for them to come and build new supply. Given the condition of Pickering and given the risk associated with redevelopment, which we are in the process of assessing, we're going to be stuck with no new energy at a time when our demand is growing at about 1% per year, at a time when we know we've got very little breathing room on the hottest and coldest days of the year, when we are importing power, and when you're importing, you're always importing it at the highest cost.

Now, we've got some good news coming down the road. Bruce A is coming on, two reactors. But again, historically, we don't have a large enough margin of safety in the context of our peak demand times. So a

combination of conservation and—what Pickering points out is just how vulnerable we are. What we're hoping to establish is an environment where there will be more natural gas plants coming into Ontario to produce what is a relatively clean form of energy so we're not on the bubble all the time, if you will. Failure to do that, in my view, would leave this province in a position—I can tell you, for instance, I met with the vehicle manufacturers yesterday. Even though electricity is about 2% of their operating costs, the nervousness around supply is an impediment to them getting product mandates—that is, new investments—in Ontario.

Mr Duguid: A final question: Aside from the political critique of the bill, I've heard nothing outside of Queen's Park from stakeholders suggesting that this is not the way to go. In fact, what I've read of comments from stakeholders is that they're fully supportive. Have you been in consultation with stakeholders to date, and what's your take on that?

Hon Mr Duncan: First of all, yes, we've had a lot of endorsement of the policy. We have to be fair about this. There are going to be segments where there is going to a substantial price increase. The two communities I'm concerned about—you'll hear from them later today—are the small business sector and farms. In both cases, they have concerns. They've also offered some other ideas, and I would invite you to question them about other areas where we can look at going forward to help them. But obviously they're not going to be happy. They are going to be looking at, in some cases, anywhere from a 14% to 17% increase, depending on the volume of usage, and I don't think we can paper over that. I think we have to be straight up. I think we have to be honest about it. I think they recognize, being people who participate in and believe in markets, that you don't get anything for free.

What I've said to them in the interim is that you are paying for this, one way or the other, either through your taxes or through the bill. Our hope is—and particularly the farming community has some tremendous ideas around conservation. One of the things I learned as part of this process is that in farm communities now, just to get bank financing you have to have backup diesel generation on your farm. So I think there are going to be a lot of opportunities going forward to assist the rural communities, recognizing that this is going to be a hard hit for them, as well as small business. But I think everybody is resolved that we've got to do the right thing in terms of generating long-term supply.

We have a choice: We can bury our heads in the sand or we can acknowledge a challenge and address the challenge going forward and encourage everybody to work together on this. But I don't want to try to pretend that there aren't going to be people affected by this. There will be.

The Chair: There are two other questioners on the list and we've got about six minutes remaining. Kathleen, then Caroline.

Ms Wynne: There are two areas that I have some concerns with. It actually follows a little bit on the oppos-

ition question around people living in large buildings. I'm worried about low-income seniors in high-rises. I'm also worried about seniors in another context, and that is people who are on a fixed income and may be living in a big, inefficient house, but who don't have a lot of flexibility in their income. I'm just wondering, how do we protect tenants, particularly senior tenants, in those large high-rises, and seniors who are living in a house that they really probably couldn't afford to buy today and whose appliances and heating systems are inefficient? How do we protect those people?

Hon Mr Duncan: We have dealt with apartments in the regs. It will be 750 times the number of units, so that protection is built in there. That's number one. The 750 cut-off wasn't done arbitrarily; there's a certain amount of art and science to it. The average household in Ontario uses about 1,000 kilowatts. About 48% of households use 750 or less. In terms of apartments, the 750 will be applied by the number of units in a building. So that's number one.

You raise an interesting dilemma with those seniors who are in their homes. I think of my mom and dad, for instance. They're both quite on in age. My dad's still in the house, and they've got the Kelvinator in the basement. The notion of him at 82 years old going out and doing all these things is a challenge. Families are going to have to help out. Where there are no families, we're hoping there will be a community response on this thing.

One of the things we'd like to see happen, and we'll be having more announcements around conservation going forward involving small homes and individuals—we do need a change in attitude. I liken it to the waste system we had in Ontario prior to about the mid-1980s. Remember the old days? We just threw all our garbage into a Glad bag. It took time. Hopefully, the price thing—for instance, I went and got all those energy-efficient lights, put them throughout my dad's house, things like that. But you raise a valid concern.

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Ms Wynne: I think we're talking about shifting the culture here. The reason this is so difficult is that we haven't stepped up to the challenge for the last 40 years. Now we really are having to play catch-up.

I'm just asking us to consider that we look at what those would be. That would be my second question, which is about public education. Jennifer Mossop raised it in the House. When electricity was being developed, there were road shows that went around the province getting people to use electricity, and we've got to do the reverse now. I know it's not part of this legislation, but we need a very extensive public education campaign, and we probably need to start with how we can help that community response with seniors and what we can do. I just raise that.

Hon Mr Duncan: I think that's a valid concern. We are going to have a conservation initiative, beginning in January. I'm not yet quite in a position to announce its entire makeup. It will be led by my parliamentary assistant.

You're right, there's a cultural shift that has to happen. It happened in the waste system. Part of it is the curriculum in the schools. We've already spoken with the Minister of Education. They're looking at incorporating this into the curriculum at schools. When my son comes home, he's much more cognizant of these things than people of my generation because they're learning them in school. I believe the schools are an important part of that. We're going to have more announcements around the curriculum on that. But you're right, there's a cultural shift that has to occur.

The Chair: Is there one brief question? The 11 o'clock delegation is not here yet, so Caroline, if you'd like to take one brief question and answer, then as a committee we can decide what to do after that.

Ms Di Cocco: Minister, you mentioned TransAlta. You may answer this or give me a follow-up later on. TransAlta is the largest cogen in Canada that has built there. As you know, Sarnia, in particular, is one of the largest users of electricity because of the petrochemical industry. What I found quite astounding is that about half of TransAlta's energy supply that it generates is for its industrial customers. The other 50% or 60% it has in excess it can't sell in Ontario until after all of the US imports have been exhausted when there is a peak period. They brought this to my attention, actually. I found that we're generating capacity in Ontario, and yet we're unable to use the cheaper—whatever that wattage is. I don't know if maybe you have a response to that. I just found that quite incredulous, actually.

Hon Mr Duncan: Well, I don't, and I find it incredulous too, so let me undertake to look into that further for you.

We want to create a climate where companies like TransAlta want to invest in private generation, and if those impediments are there for no good reason, then we need to get to the bottom of it. I'll undertake to write back to you with a better response than I've given you today.

The Chair: Our 11 o'clock has just arrived. Good timing.

CONSERVATION COUNCIL OF ONTARIO

The Chair: Mr Winter, if you would have a seat, you have 20 minutes, of which we've used about two or three already. You can use that time any way you like. Leave some time for questions, if you'd like, at the end.

Mr Chris Winter: My apologies for the delay. I think it's a new security system at the front and it takes a bit of time to get through now, especially if there's a bunch of school kids ahead of you.

Thank you very much, everyone. It's a pleasure to be here.

The Chair: Could you identify yourself for Hansard?

Mr Winter: Yes, I will indeed. My name is Chris Winter. I'm the executive director for the Conservation Council of Ontario, which is a 50-year-old organization with 25 member organizations, 50 individual conserva-

tion leaders and over one million constituent members, ie the members of our member organizations. We represent the interests of conservation in Ontario, and in this instance the interest of conserving energy through demand management, efficiency and renewable power alternatives.

I don't think anyone will deny the importance of conservation as a first step in creating a secure electricity system, an efficient economy, a healthy environment, comfortable homes and reduced energy bills. I doubt if anyone will deny either that it is the most cost-effective means of addressing our current power crunch. The question is, if we all agree conservation is so important, then why is the financial support for conservation so abysmally low?

On August 14, the blackout reminded us all of the importance of conservation. We heard our political leaders utter the word "conservation" more times in the space of one week than we had heard over the past eight years in total. It was just absolutely incredible. We saw opinion polls that said that over 80% of the public wanted to conserve more energy, and that this was more than just the immediate reaction to the blackout. It was a deep concern for energy conservation and they were looking for leadership from their government.

The Conservation Council released a four-point energy conservation action plan shortly after, and that combined pricing, subsidies, public outreach and standards. It is a simple yet comprehensive approach. A full copy of the plan is attached to these remarks. The key points of it are to price energy to promote conservation; establish an Ontario green energy and conservation fund; support community-based conservation outreach and education campaigns; and improve standards for renewable power and energy efficiency in appliances, homes and urban design.

Bill 4 addresses the first point admirably. The 0.8 cents per kilowatt-hour gap between the conservation and over-consumption rates sends a very clear pricing message to the public in Ontario. My congratulations for that measure.

Now to the problem, and yes, there is a problem. I think Bill 4, as it is currently written, effectively eliminates the province's ability to generate revenue for an effective provincial energy conservation program.

The first problem is that the price may still be too low. With an average price of at least five cents per kilowatt hour, about half of Ontario's residential users will still be paying a highly subsidized rate of 4.7 cents per kilowatt hour for their electricity.

Second, section 12 of the bill requires that any revenue from the new pricing structure will be returned to consumers via reduced rates. This effectively eliminates any possibility of using the revenue from over-consumption to offset any price gap for conservation and renewables. It eliminates the possibility of establishing a provincial green energy and conservation fund. It effectively eliminates the role of the Ministry of Energy as a lead advocate for conservation.

In essence, it means the only option for promoting conservation is through utility-driven conservation programs. While I wholeheartedly support the involvement of local utilities in demand management as a provider of goods and services to the public, I believe we still need strong provincial leadership in conservation outreach, subsidies and support programs. Why is this important? Let me give you an idea of what is needed to rebuild conservation capacity in Ontario.

We need a province-wide challenge program, a partnership of provincial, municipal and federal governments, and of retailers, utilities and non-governmental organizations to promote energy conservation. It should focus on energy conservation, but link electricity security, economic savings, home comfort, clean air and climate change as motivating factors. No matter where you come from on this picture, all roads lead to energy conservation as a first step.

We need a one-window information Web portal and 1-800 numbers for conservation and renewable energy resources. The public is asking for information. I get at least one call a week saying, "Where do I get something? Where do I find a solar heater? Where do I find wind power? I want something for my home." They need access to that information. Even basic stuff like that we don't have.

We need a kit of community-based project ideas to promote energy conservation, one that can be adapted to any community across Ontario. There are some excellent models of community-based projects that have been developed. We need to package and put them together and roll them out to communities across Ontario.

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We need to build the capacity of major organizations to provide support services, groups like the Green Communities Association, EnerAct, Ontario Sustainable Energy Association. There are a number of very good organizations, and in fact, as an aside, I sit on the board of Green\$aver, which is the Toronto Green Community, and I can tell you the problems that Green\$aver and other green communities are having right now to ramp up to deliver the EnerGuide for Houses program are tremendous. We're going to run into that same capacity problem with other conservation programs, so we need action right now to start rebuilding the conservation movement in Ontario.

We need community demonstration centres for conservation and renewables. People need to have a place to go wherever they live where they can see this stuff in action.

We need community open-house workshops in neighbourhoods so that someone opens their house and we do a run-through and everybody gets a chance to see this is what it would look like if you change light bulbs, if you do draft-proofing, if you do a home energy audit.

We need door-to-door contact programs. We've got kids out there selling chocolate bars and useless home products. Instead, they should be out there selling energy-efficient light bulbs and handing people information about what we can do.

We need conservation ambassadors. There was an amazing program done through the Toronto Chinese Health Education Committee, TCHEC, that created ambassadors who went out to community events and educated people about environmental issues. We need to replicate that program across cultural and municipal communities.

So Ontario needs to take immediate action to begin the rebuilding process for meaningful conservation programs. We need to rebuild the conservation movement in Ontario. Our estimate, which I would be glad to go into in detail any later time, is that it will require about \$20 million a year for developing community networks and outreach programs and an additional \$15 million for developing provincial outreach and support programs within the NGO community.

The other key point is that we need to set aside sufficient funds to eliminate the price gap between conservation solutions and the conventional polluting option. These funds need to flow directly to the individual as rewards for conservation activities.

We think Ontario needs to identify at least \$250 million a year to subsidize and promote conservation and renewable energy programs. For example, a 25% subsidy on 100,000 solar roof installations, which was recommended in the select committee on alternative fuel sources, would cost up to \$100 million to implement. Ontario needs to act immediately to source this funding.

This may seem an unreasonable request with a \$5.6-billion deficit, but I ask you to compare it to the cost of refurbishing Pickering or building new polluting capacity in Ontario. One billion dollars over four years to obtain up to 4,000 megawatts of saved capacity is an extremely good investment.

Therefore, in conclusion, I would ask you to take the following actions:

- (1) Amend section 12 of the bill to allow for the creation of an Ontario green energy and conservation fund that would disburse all net revenue back to consumers via conservation and green power subsidies.

2. Require the OEB to set a price for electricity that includes revenues of up to \$500 million per year for the green energy and conservation fund.

3. Take immediate steps to begin rebuilding conservation capacity and the conservation movement in Ontario.

I thank you for your time.

The Chair: Thank you, Chris. You've conserved about eight minutes of your time for questions. I'm going to propose that that be split between the two parties.

Mr Jackson: Chris, thank you for an excellent presentation. I was struck by your notion that Ontario needs to act immediately. As you know, in Bill 210, when the first cap was placed, there was a green power initiative which was detailed with an investment by the provincial government of the day. It also had tax subsidies for individuals and corporations that would conserve. You make reference in here to conservation outreach subsidies and support programs. Am I to

understand that both those that I've just mentioned are just some of the ones you're referencing?

Mr Winter: I think what we've seen in the past is just scratching the surface.

Mr Jackson: That wasn't my question. My question was, is that the category that you are promoting?

Mr Winter: There are two categories. One is building the human infrastructure, the outreach services.

Mr Jackson: No, I get all that. The point is the tax incentives—

Mr Winter: The taxes would be part of the second part—

Mr Jackson: Very good.

Mr Winter: —of subsidies to eliminate the gap between conventional and alternatives.

Mr Jackson: And it drives down utilization.

Mr Winter: Exactly.

Mr Jackson: Which is what you want to happen.

Mr Winter: Yes.

Mr Jackson: The point I'm getting at is that the government has seen fit not to do any conservation measures in this first round of its discussions. It's only going to use the pricing mechanism. We feel that this is an opportunity lost, given that there is a tremendous amount of good work going on. It was organized through the Ministry of Energy at the time and it was beginning to do some extensive work. That apparently has all been put on hold. You're suggesting that that not be put on hold and that you've enhanced the notion by suggesting that a fund be established that can drive that even further.

Mr Winter: Yes, and what I'm suggesting is that this bill may make it even more difficult to implement some of those measures because it is taking out the possibility of identifying and targeting revenue from pricing and the surcharge, or systems benefit fund if you prefer, taking away that capacity to apply it to conservation because it is regulating or requiring that that money be put back into rates in the form of subsidized rates. That, I think, is a serious problem.

The Chair: I've got Jim, Kim and Donna and we've got about four minutes. Jim, would you like to kick off?

Mr Jim Brownell (Stormont-Dundas-Charlottenburgh): Yes. Thank you very much for your presentation. I found it very enlightening, meaningful and certainly some good food for thought. As a retired educator, it was always the idea and experience that had youth out there promoting conservation. Back in the 1980s and early 1990s, in my classroom it was reduce, reuse, recycle, and they did a great job on that.

That brings me to the conservation programs that you've alluded to. You talked about the immediate action and the process, and you had estimates and costs—this will require \$20 million per year for developing. Could you elaborate on that a little more, how you came to those figures?

Mr Winter: The way we came to the figures is that there are 446 municipalities in Ontario. Not all of those municipalities will need organizing, because there's overlap between them, but essentially we need to identify

funding, make available to each municipality a matching base of funding for developing a community network, a community action plan, priorities, to build the capacity within the community so that we can plug a provincial energy campaign into those communities that want to get involved in doing that. It would dovetail as well with work that utilities might be doing through utility-driven conservation programs. But it essentially is addressing the public outreach and support services for the public through a community-based program.

The way I came at that cost would have been looking at the former green communities program, which I think was \$250,000 per community. I don't think we need anywhere near that amount; \$50,000 to \$100,000 per community, depending on the size of the community, would be adequate, and then scale it over a four-year period to build up capacity in communities to make that funding available. So that's the community capacity-building component.

I think you could dovetail that in very easily with the Trillium Foundation and the role of the Trillium Foundation to build community capacity. So there are some ways that you can look at that and look at existing funding that you have within the government to use it more effectively. But if we're talking about Trillium, I think you also need to look at augmenting the Trillium budget. I believe about 5% of gaming revenue goes to Trillium. I'd prefer to see 25%, but I'll settle for 10%.

The other aspect of that is the \$10 million to \$15 million, which would include about \$2 million to \$3 million for developing the provincial campaigns with organizations that are leaders in conservation and renewables, and then the rest of it would be for implementing that, again at the community level. So the main thrust of this is community-based outreach.

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The Chair: The next question is from Kim.

Mr Kim Craitor (Niagara Falls): I'll pass, thank you.

Mrs Donna H. Cansfield (Etobicoke Centre): I have a question. You had indicated earlier, I think, that there's an issue around culture change and that you had to have the time to build the capacity. I'm interested more in the concept around sustainability. The minister previously indicated that there will be a very comprehensive approach to conservation that will be starting in January, the details of which he wasn't at liberty to discuss at this time. But the concept of sustainability is the balance amongst society, environment and economy—you can't swing one way, you have to have that balance—and yet I don't notice that in your discussion here. It just seems on the conservation side. I wondered if you enlighten me on your thoughts around the concept of sustainability.

Mr Winter: It's interesting. The Conservation Council of Ontario is 50 years old. We were set up to promote conservation. In the 1980s, with the sustainable development movement, we found ourselves drifting into promoting sustainable development, and then in the 1990s it was pollution prevention and the green plan, and along

the way you get the natural step, you get eco-action, you get various terms that are basically saying the same thing. It's something we found too with climate change, with energy security, with smog—all these starting points lead to the same thing: we need to cut back the amount we consume. So whatever language you're putting on it, the actions are pretty much the same.

I think what we realized is that we need to get back to that core mission of promoting a conserver society but at the same time embrace all these different aspects and manifestations of it. So sustainability is definitely a big part, and has been a big part, of our approach to conservation—and also the link between economic and social factors. We're a founding member of the Ontario Healthy Communities Coalition. We embrace and support that kind of holistic approach to conservation. The key thing is, though, that we have lost the conservation or the environmental part in the last 10 years. I would not say it is entirely a political issue; it has been a social issue. Society drifted from an awareness and support for the common good and the commons, being the environment. It was very much a me-centred decade. I think we're seeing a shift back to that, back to an awareness that we need to have a healthy environment, we need to support communities. So I am extremely encouraged by what I have seen on the ground in the last six months to a year in terms of a shift and an awareness.

What we need to do is capitalize on that and rebuild—or build where there never really was—the social movement that says conservation and environment are a priority for us. If you look back over 20 years, 30 years, we never really have had that movement in the way that we are talking now about how we need to build it. It needs to be on a par with the social movement, with social justice, with health, with economic development. It needs to be on a par. We have never, never even been close to being on equal footing. That's my view on sustainability and the balance between the three.

The Chair: In order to keep everyone on equal footing, everyone gets a fair share of time, and you've used yours up, unfortunately.

Mrs Cansfield: It's identical to mine, thank you.

Mr Winter: Excellent. I look forward to working—

The Chair: I'd like to thank you for coming, Chris. It was a pleasure having you at the committee.

ONTARIO CLEAN AIR ALLIANCE

The Chair: Our next delegation is Jack Gibbons, from the Ontario Clean Air Alliance. You have 20 minutes to use as you wish. Any time at the end will be used for questions, split evenly between the two parties that are present.

Mr Jack Gibbons: I'm Jack Gibbons and I'm chair of the Ontario Clean Air Alliance. Mr Flynn, members of the committee, thank you very much for the opportunity to talk to you today about Bill 4.

The Ontario Clean Air Alliance strongly supports the government's decision to raise the electricity price cap

and we also strongly support the government's decision to permit Ontario electric utilities to raise their rates by three tenths of a cent per kilowatt hour to finance energy conservation and efficiency programs.

Energy conservation and efficiency programs provide multiple benefits for the province of Ontario. First, they can reduce customers' bills; second, they can help make Ontario's industries more competitive; and third, they can help phase out the dirty coal-fired power plants. Energy efficiency is the best way to phase out the coal plants because it creates no pollution and it reduces customers' bills and makes the economy more competitive. So everyone gains from energy efficiency when those dollars are spent well.

According to the Ministry of Energy, the proposed surcharge for energy efficiency, three tenths of a cent per kilowatt hour, can generate a \$225-million energy efficiency fund. That's a lot of money, and it has the potential to provide very large bill savings. If the electric energy efficiency programs are as effective as those of Enbridge Gas Distribution, they could be reducing customers' bills by \$1.8 billion. There is a potentially huge payoff for Ontario from this proposal.

But the problem is, at the moment, given the Ontario Energy Board's status quo rules for regulating the electric utilities, the promotion of energy efficiency is not in the economic self-interest of the electric utilities, be it Toronto Hydro or Hamilton Hydro or Hydro Mississauga, now called Enersource. The way the OEB regulates the utilities, their profits are linked to how much electricity they sell, so their profits go up when they sell more electricity and their profits go down when they promote energy efficiency. That's why none of the electric utilities in this province have serious energy conservation programs.

If that perverse incentive isn't corrected, what are the utilities going to do? Just remember, under the status quo rules, it will be in the utilities' financial self-interest to spend this \$225 million in a way that leads to no reduction in electricity consumption. To be totally crass, their narrow financial self-interest will be to waste this money, because if they promote it effectively, they are going to reduce their profits. So it's absolutely essential that, before they're given this money, changes must be made to the regulatory framework.

First of all, a lost revenue adjustment mechanism must be created. That mechanism will ensure that when the utilities promote energy efficiency, their revenues and their profits don't go down. That's an absolute essential. You can't penalize them for promoting efficiency if you want them to do it seriously and cost effectively. So a lost revenue adjustment mechanism is needed to reduce the existing penalty for promoting energy conservation. But that's not good enough if we want to get the maximum possible bang for that \$225-million buck, because the lost revenue adjustment mechanism just reduces the penalty; it doesn't give them a financial incentive to get the biggest possible bang for their buck, to get the most effective and the most aggressive possible energy conservation programs.

So what we also have to do is change the way electric utilities are regulated so that energy efficiency becomes their most profitable course of action. If you make it their most profitable course of action, yes, they'll do a very good job. What we need is what we have on the gas side for Enbridge Gas Distribution: a shared savings mechanism, which gives the utilities a percentage of the total bill savings they achieve for their customers. For example, the shared savings mechanism could give 5% of bill savings to the utilities as a shareholder bonus and 95% of the bill savings would stay with the customer. That means the vast majority of the benefits go to the customers. The customers are better off and the utilities are better off. The utilities have a motive to actually develop good energy conservation programs. The municipal utilities shareholders, be it the city of Burlington or Aurora, will have extra revenues and profits for municipal services.

This is a mechanism that, again, is win-win for everyone, and it's absolutely essential. If this money is to be spent wisely, they have to have an incentive to do it right. For example, under the previous government, the Ontario Energy Board established a shared savings mechanism for Enbridge Gas Distribution in 1998. As a result of that financial incentive mechanism, Enbridge gas has developed the best energy conservation programs in Canada. Before that incentive was in place, they always failed to achieve their targets. As soon as the incentive was in place, they hugely overachieved their targets. Enbridge's energy efficiency programs are reducing their customers' bills by \$680 million, and the shareholder profit bonuses so far have been \$12.9 million. So the vast majority of the benefits goes to the customers, but the utility is also rewarded, and they are therefore very keen about doing a good job.

That is the absolutely key message that I implore of you, to make sure these incentive mechanisms are put in place before the utilities get their hands on that \$225 million.

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There are two other recommendations I would like to make for you. To get the biggest bang for the buck in terms of energy conservation for their customers, you must insist that all this \$225 million is spent on energy conservation programs on the customer's side of the meter. If you don't say it has to be on the customer's side of the meter, the utilities will come before you with all kinds of ways of how they can make their own system more efficient, how they can install new meters, which are good. They are going to be giving you all kinds of reasons to divert all that money to their traditional line of business. Those traditional things are good, but you've got to remember that under the existing rate structures, they have all the money they need to do those traditional activities of installing meters, of saving energy in their own buildings, on their own distribution lines. You don't need to give them an extra penny for that. They've already got a financial incentive to do that. It's already part of their business. You've got to make sure all that

money, though, is spent on the customer's side of the meter to give the biggest possible bang for the buck for your constituents.

One final thing: The proposal from Minister Duncan allows the electric utilities, the distribution utilities to raise their rates to finance energy efficiency programs. But there's also Hydro One, which has two parts. One is a distribution company; it serves all kinds of rural customers and customers in Brampton. But Hydro One is also a transmission company, and as a transmission company, it serves the largest industrial customers in this province, like Inco and Stelco, directly. Minister Duncan's proposal is silent on Hydro One being able to put a conservation surcharge on the large industrial customers to finance industrial energy conservation programs, and that's something that needs to be added to help make those industries more competitive and help to reduce their pollution.

Thank you very much for your attention. If you've got any questions, I'd be glad to answer them.

The Chair: Thank you, Jack. You've used up about seven minutes of your time, so we'll split the remaining 13 as closely as we can. We'll start this time with the government side. Are there any questions?

Ms Di Cocco: Thank you for the presentation and for the advice that you have provided to us. You're talking about the metering and the incentive for the \$225 million to budget, to somehow be directed to the customer in providing this new metering. Can you just expand a little bit on that?

Mr Gibbons: I'm saying that none of this \$225 million should be used for metering.

Ms Di Cocco: OK. None of it should be.

Mr Gibbons: None of it. Because electric utilities have been installing meters for over 100 years. As long as there have been electric utilities, there have been meters. They have a budget for meters. That's a traditional activity of the utilities. They've got enough money for meters in their regular rates. What they do is they make their capital investments, they put in their rate base and they recover the costs over the expected life of the meter. So there's a traditional way to finance meters, and you don't need to devote any of this money to meters, though I'm sure you're going to hear electric utilities saying, "Oh, we need these fancy new meters, and we need to divert all this money to meters and none of it for the customers."

I just say beware of that. There are already existing procedures to recover the costs of meters. The money should all be for programs in your constituents' homes and offices and factories to make those homes and offices and factories more energy-efficient.

Ms Di Cocco: I guess the reason I go to that point is because I understand. I certainly asked my own utility what it costs to put, let's say, a meter—is it time?—I can't remember the name.

Mr Gibbons: Time-of-use or interval meter.

Ms Di Cocco: Yes, time-of-use metering. They cost \$350. They already have a cost recovery for that in place.

I had understood that you had said it should go to the metering, so I was—

Mr Gibbons: No, I was trying to say all money on the customer's side of the meter, which is sort of industry lingo for in the customer's house or office or factory.

Ms Di Cocco: It was my understanding. Thank you very much.

The Chair: Any other questions from the government side? If not, we've got about seven or eight minutes left, Cam and Frank, if you'd like to use that time up.

Mr Jackson: Jack, thank you. In a very brief time you've covered a lot of area and you've stimulated us to raise some pretty significant questions. I want to get right at this one about where the utilities might sit and spend this quarter of a billion dollars. I raised the questions yesterday with the staff whether technically, under your guidelines, if I was Burlington Hydro, I could convert all of the vehicles, including the executive director's chauffeur-driven car, I could get that converted to natural gas and that would qualify, and they said yes. So I think your point is a very valid one.

However, we all have a whole series of scenarios. It's the metering that intrigues me. Right now, it's a fallacy that you're really saving money by putting your dryer on at midnight. You're using less costly energy because of a blended rate, therefore you're increasing the profits of your utility, is essentially what you're doing. The public doesn't get that part of it. I'm interested in the notion—and I'm sure the person who spoke before you, Chris Winter, would agree—where we're trying to move to an area where someone can use solar power and wind power in their backyard or their farm or in a rural area. But they need a meter on their house that says, "When I have excess wind power at 2 o'clock in the morning, I'd like to be able to put that back into the grid and I'd like to have my bill reduced accordingly." You'd implied something about the metering. But would you not agree that there's an example of that kind of connect in the full context of allowing the consumer to actually reduce consumption and contribute green energy back into the grid, that in that sense those kinds of metering would be appropriate? However, there's not a lot of technology on it and the resistance, the gate is that there's no real financial incentive for the utility to buy back energy from a consumer. They sell energy, they don't buy energy at cheap rates. Well, they mark it up when they buy it at cheap rates.

Can you comment specifically about that example? Because we're going to be doing regulations about this process and we need to have a fine-tuning of it. And I have a question about tax incentives.

Mr Gibbons: Yes, Mr Jackson, I certainly agree with you. Basically, you're talking about running the meter backwards so you can export your green power to the grid when you don't need it. That's an excellent example. It definitely should be done. It was something that Toronto Hydro used to do; I'm not sure they still do. I know Minister Baird was proposing to do that. Yes, it should be done. Please don't interpret my remarks to be

against sophisticated meters—absolutely not. Those types of meters are good, as are time-of-use, as are interval meters. My point is simply that meters are a capital expenditure, they're a traditional utility activity. What utilities do with meter costs is that they make the capital investment. They rate-base it, as they call it. They invest in their capital stock and they recover the costs in their rates over the life of the meter. The point I'm trying to make is that there is an existing mechanism for them to recover their costs of meters. And these new meters will be more expensive than the old simplistic ones. Yes, they will have to spend more money on meters, but there is an existing mechanism to recover those costs, and I'm suggesting that mechanism should be used so that we don't have this \$225 million diverted to meters or to fancy natural-gas-powered Jaguars for their president or something.

Mr Jackson: There are a couple of examples that I raised the other day, and I have concern in this area. Earlier today the minister confirmed that it's possible for the local distribution companies to actually claim and recapture the recoverables that OEB has already approved and that is on standby, plus get the three cents so that they are guaranteed their 10% profit. Then there can immediately begin the process of a third application to OEB for another rate increase—the other one is retroactive. My concern is that some utilities could create companies within their own company, which I know a few have, so that they control the market, so that they create a secondary profit centre on the market they control, doing the metering and doing those other activities. So it's an inflated price that they present to the OEB. Because they're subcontracting, there's a huge number of games that can be played here, all under this umbrella of the \$225 million that's allegedly for "conservation measures."

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I'm going to run out of time, so I want to put on the other issue. I'm glad you raised—we haven't had much input yet, and I'm hoping we will get more input—the fact that even though they're only 2% of the total consumers, the large industrial consumes half the energy. I'm glad you raised the issue about why all these mechanisms are in place for senior citizens and consumers and small business but the legislation has been silent on the industrial side. I'm sure the committee will be pleased to ask the minister why it was silent on the conservation surcharge that would affect the large industrial. I have an inkling when you look at the pricing system. These people are buying hydro at a very cheap rate, in bulk, which the consumer cannot. If anything, their profitability is extended and the consumer's ability to pay is compromised. You may want to expand a little further on that second suggestion of yours about Hydro One's direct customers in the industrial sector, because they have not presented in any fashion to us. Maybe that's why.

Mr Gibbons: The first issue you raised, about whether these utilities would contract out to subsidiaries and buy back the services at inflated costs, that's an

affiliate transaction, and yes, I think you're very correct to be concerned about that. That is a potential for abuse. The Ontario Energy Board does have an affiliate transactions code which says that when they buy from affiliates it must be at market price, so that is in theory supposed to deal with it. I think some people could be cynical and say, "How well can the OEB deal with that?"

Mr Jackson: It's a monopoly market.

Mr Gibbons: So you might want to make the provision that all the energy efficiency spending cannot be done through affiliates, if you are really concerned about that and don't think the OEB can properly police it.

In terms of the large industrial customers, I think there's tremendous potential for a cost-effective energy efficiency there. In terms of the gas utilities, they found the most cost-effective energy efficiency investments are in the industrial side, by far the most cost-effective, and so I think it's really important that money be created for Hydro One to develop energy efficiency programs there if we want to get the biggest possible bang for our buck.

The Chair: Our 11:40 is on the subway and is almost here, so I'm just going to let Donna ask maybe one more question and then we'll end.

Mrs Cansfield: I have a couple of comments and then a question. Most large industrial customers currently pay market price for energy and most of them also use interval metering at this point, so when you look to the issue around conservation, I would be really interested in what you think those kinds of initiatives could be. I appreciate that may be a discussion that will occur next January.

The one thing that I was interested in is the issue around interval metering. Time-of-use metering appears to be outdated. Interval metering can also read water and gas at the same time as dealing with electricity. Do you not think that there would be an opportunity with the customer and the distribution company to sit down and look at alternatives other than just—that type of meter would benefit because you're not having three people come out to read meters as opposed to one. You probably have a better use of the metering in terms of the time you use it. You could look at peak times, which is what I think my colleague across the way was suggesting, which we currently don't have, so that sometimes you would have a lower cost for doing your dishes at midnight as opposed to at 6 in the evening, and currently it's the same price regardless of when you do your dishes. Have you got any thoughts about why that couldn't be part of a broader discussion with the customer and the LDC and the multiple use of the interval meter?

Mr Gibbons: No, you're absolutely correct. Much more sophisticated meter technologies are being developed, and they provide huge benefits, as you mentioned, in terms of pricing varying by the time of day or by every 15 minutes, and in terms of being able to read all the meters electronically—gas, water and electricity. There's no doubt there are huge potential benefits. It definitely needs to be investigated.

I would just warn you, it's a very technical subject. There are lots of different metering companies out there, lots of different metering salesmen. To figure out exactly what is the best technology, is not a simple question and it needs a lot of study. It will probably vary across this province. This is a huge, diverse province. I don't think there will be one metering solution that's best for all the province or all types of customers.

Mrs Cansfield: I concur. I wasn't suggesting that. I was just suggesting that there might be an opportunity for discussion within the different municipalities, because the needs are different. You go in the far north, it's a little bit different from the eastern or the southern parts of this province. Thank you very much.

The Chair: Thanks for attending, Jack.

Mr Gibbons: Thank you very much, Mr Flynn, and members of the committee.

The Chair: Did you have a final question, Frank?

Mr Klees: If you've got time.

The Chair: We seem to have some time to kill, unless there's a lady named Fiona Oliver who walks in that door. Would you answer one more question, Jack?

Mr Gibbons: I can answer as many questions as you fire at me, or try to.

The Chair: We should use the time wisely, I think. Go ahead.

Mr Klees: Thanks for your presentation. There are some excellent recommendations.

You're well familiar with the industry. You've seen the functioning of the OEB over the years. I think the proposal here is to put a great deal of onus on the OEB to regulate the kind of issues that you're referring to in terms of this \$40 million. Are you comfortable that the OEB should be left with that responsibility, or do you see a more proactive role for the government of the day to provide some clear direction to the OEB as it's charged with making its decisions on these things? I know that in the past there have often been conflicts with the OEB's mandate being very specifically focused. Often the perhaps expressed or implied policy will of the government of the day ends up not being implemented because of that disconnect. I'm concerned that perhaps a very well-intentioned policy may not in the end be implemented because of that disconnect. I'd be interested in your comments.

Mr Gibbons: Mr Klees, you're absolutely correct. The previous government, in my opinion, gave a number of very good policy directions to the OEB. I was very frustrated because I didn't believe the OEB was following them nearly as aggressively as they should have. The OEB is a little subculture. It's a bureaucracy. Many people have been there for many years and have very strong opinions about how the world should work, and often those strong opinions are contrary to those of the government. So it's absolutely essential that it be a very clear policy directive, and you have to watch them very

carefully to make sure they're actually doing what you told them to do.

So I would suggest to the new government that they must send a very clear direction in terms of the electric utilities promoting energy conservation. Despite all the things the former select committee on alternative fuels said, despite the amendments to the OEB act made by the previous government that clearly said they should promote energy efficiency, despite the fact that this government is now giving a \$225-million budget for energy conservation, there are still people at the OEB today—I just came from an OEB meeting—debating whether the electric utilities should promote energy conservation. It is unbelievable how out of sync they are with the wishes of all three political parties in this province. So yes, the government must give very strong direction. Even with the \$225 million, a lot of people still don't get it. You have to hit them over the head with a hammer or a sledgehammer to make it perfectly clear what you want. You've got to watch them and make sure they do it.

Give that policy direction. The OEB is the economic regulator. It does have expertise. Then they can hold the utilities accountable and make sure that the utilities actually spend this money wisely.

Mr Klees: Mr Gibbons, I wanted to get you on the record on that issue, and I thank you. This goes to a statement that the minister made in his opening remarks, when he said, I'm sure with all good intentions, "We want to take the politics and politicians out of energy policy."

I maintain that there is a very strong role for politicians to play in setting energy policy and ensuring in fact that it is implemented. To your point, we want to be helpful to the government in achieving their objective. I believe very firmly that this issue of having the OEB firmly on side, if you will, with the policy of the government of the day is absolutely critical, and I urge the minister, the ministry, to look at this very carefully, to consult with the industry, who know full well what happens at the OEB. Because they appear before them day in and day out, the industry often understands what the intent of the government's policy is, and the industry is frustrated with the end result and the directives that are given by the OEB. Thank you very much for your input.

The Chair: Thank you for attending, Jack. It was a pleasure having you here.

1150

CANADIAN ENERGY EFFICIENCY ALLIANCE

The Chair: Our 11:40 delegation has arrived, Fiona Oliver from the Canadian Energy Efficiency Alliance. Please state your name for Hansard.

Ms Fiona Oliver: I'm Fiona Oliver, and I represent the Canadian Energy Efficiency Alliance.

The Chair: Typically, we allow 20 minutes for delegations, including any time you leave over at the end for questions.

Ms Oliver: I probably will be shorter than that.

The Chair: That would be wonderful. Thank you.

Ms Oliver: Among the items we want to cover today is to give you a sense of what the alliance is and then speak to Bill 4, which has been introduced by the Minister of Energy, Dwight Duncan.

The Canadian Energy Efficiency Alliance is the leading independent voice in Canada to advance energy efficiency and its related benefits to the economy and to the environment. The Canadian Energy Efficiency Alliance has been advocating for energy efficiency for over seven years. We represent leading utilities, manufacturers, energy consultants, consumer and environmental groups, including Enbridge Gas Distribution, Consumers Council of Canada, Pollution Probe, Ontario Power Generation and many others.

Our main objectives are to engage with provincial and federal governments to develop and maintain energy efficiency policies, programs, codes and standards; to monitor and report on government activity—we do this through our annual report card, which many of you may have seen over the past four years; assist members in the development, delivery and promotion of their energy efficiency initiatives; and raise the public profile on energy efficiency.

I'm going to skip over some of our clarifications on terminology and just go straight to our thoughts on Bill 4. I'd first like to say that we're very pleased that the government, within only a month of being in office, has moved so quickly on the issue of electricity. We feel that Energy Minister Dwight Duncan's Bill 4 is a step in the right direction to accurate reflection of true electricity costs and therefore gives consumers the right signals for energy efficiency and conservation. This is good for consumers' bills and for the environment.

The Canadian Energy Efficiency Alliance sees Bill 4 as a step in the right direction because it is transitional and short-term. The government defined the new pricing as an interim plan until the OEB develops new mechanisms for setting prices in the future. We think this is good because it does take the processes out of the government per se and puts them into more objective mechanisms.

We feel that two-tiered is effective because it helps encourage people to take advantage of the lower rate should they be using an appropriate amount of energy and then a higher rate if they're not conserving or they're using more than their fair share. It's more reflective of true market costs and provides investment for energy efficiency initiatives. However, it's not the perfect answer; there is still more headway to be made in Ontario for energy efficiency.

I'll start off with talking about building codes as well. Even if the price of electricity was as high and accurate as it should be, there are still barriers to energy efficiency; for example, the builder versus owner-operator

situation. Builders will typically build as cheaply as possible. This leaves owner-operators with the high operating costs resulting from minimum standard building. Ontario has been a leader in codes and standards in the past and should continue to make strides on this front by raising regulated codes and standards for commercial buildings, residential buildings and appliances.

I'm just going to briefly explain our model of energy efficiency as a house. It's quite an interesting model and I think it represents very nicely two aspects of energy efficiency. We all essentially live in the house of energy efficiency. Consider that there's a roof and there's a floor. The roof is the opportunities for people to become more energy-efficient; for example, the putting in place of R-2000 homes, Energy Star-qualified appliances, and other incentives to show and help people be the most energy efficient they can, with the opportunity. The floor provides the regulations. Basically, what we're trying to do is move up the house, and we see that there are two aspects to that, not only with the money that's been provided for energy efficiency, which we think is an excellent short-term step, and we'd like to see that investment into energy efficiency continued long-term, but also raising the regulations around codes and standards. That continues to move us up in our house of energy efficiency.

To conclude, Ontario must recognize energy efficiency measures as a top priority for cost-effective reductions in emissions, new sources of supply and job creation. We do have reports on this if anyone is interested, on how energy efficiency can lead to job creation.

These investments into energy efficiency should be sustained and long-term, regardless of the government in place. This is raising the roof. Codes and standards for buildings and appliances need to be continually raised and assessed, and that's lifting the floor. The price cap should be removed in 2006, or sooner if possible. Pricing should be close to true market cost to make the market work more effectively by giving consumers the right price signals. Thank you.

The Chair: Thank you very much. I'm going to suggest we give each side five minutes for questions. Cam or Frank, do you have any questions?

Mr Jackson: Yes. Do you have a written submission or a list of your coalition members that you can share with the committee?

Ms Oliver: Yes, we do. I don't have one here with me now but I certainly can provide that.

Mr Jackson: Do you have a Web site we can check?

Ms Oliver: We do. It's www.energyefficiency.org. I'm not sure if the Web site lists all of our members or not. I'm not sure how updated it is in terms of that because I know we've gained a couple of new ones in the past few months.

Mr Jackson: Fiona, what is your current title with this organization?

Ms Oliver: I'm the operating officer. The executive director's away all day at a conference on renewables.

Mr Jackson: Could you just give us a list of who you represent? You said it was leading utilities, distribution companies—Hydro One gives funding to you?

Ms Oliver: I think Hydro One is on our list of members. Yes, I believe they are; and manufacturers such as Owens Corning, Honeywell, Consumers Council of Canada, Consumers' Association of Canada and other NGOs as well—AQME in Quebec and Pollution Probe here in Toronto.

Mr Jackson: Mr Chairman, perhaps this a question for you. Are we then to assume that Fiona Oliver is the only person who will be coming before this board representing the utilities, the distribution companies, Hydro One and the commercial infrastructure for hydro in this province? Is that what we're to assume from this list?

The Chair: From this list, I think you should assume that.

Mr Jackson: Frankly, I'd prefer to look at the list of who they represent, and we'll leave it at that.

1200

The Chair: Frank, any questions?

Mr Klees: Just one, if I might. We've had representation here about the funds that are going to be potentially generated to address conservation issues. Have you drawn any conclusions about the appropriateness of that program and how those monies then will ultimately will be allocated? Do you have any sense of whether the government should be more or less proactive in ensuring that those funds are in fact used for the purpose intended? I'd just be interested in your views as to whether you've gone down that road.

Ms Oliver: We definitely think that the LDCs, the local distribution companies, should be able to apply for funding as soon as possible. I believe there are currently some in-depth analyses going on about what's the best model for delivery of demand-side management programs. I think they're looking between two models: the central agency model and the different distribution companies, looking at that as another model. I would not be able to say on behalf of our members that we would prescribe a certain viewpoint out of those two. But I know that we are involved with the process and the analysis that's going on at the moment.

Mr Klees: Do you have any representation in your organization from the retail sector of the electricity or energy industry?

Ms Oliver: Meaning OZZ Corp?

Mr Klees: People who sell natural gas or who sell electricity to the consumer. Do you have representation—

Ms Oliver: We don't have Direct Energy. We do have the OZZ Corp, which is somewhat of a retailer. So yes, we do.

Mr Klees: Do you see a role for the retail sector in terms of either delivering conservation programs, perhaps adding conservation programs as a value added to their energy products? Is that something that you're looking at in terms of encouraging distribution? It's one thing to

have a program, the other is how you get it to the consumer.

Ms Oliver: Yes. I think you have a good point. I do think they have a role. The more comprehensive you can make energy efficiency plans, the more inclusive you can make them across different segments of our community, they will be a lot more successful. The more players that you can get involved with energy efficiency initiatives the better.

The Chair: First from Jim and then Brad.

Mr Brownell: Having served as a councillor in a municipality for a number of years, I've been very involved with building codes and whatnot. I was very interested in what you presented here about builders building often as cheaply as possible and that code should be assessed and improved. Very briefly, what success have you had in the past with regard to your alliance improving codes or encouraging the improvement of codes?

Ms Oliver: The Canadian Energy Efficiency Alliance is the main shareholder of EnerQuality Corp, which runs the R-2000 in Ontario, so we are very involved with codes on that front. We have people in our office who are always talking to builders about blower door tests and various things like that. I couldn't tell you specifically in terms of raising the regulations. I know that we always put in submissions when there are opportunities, but R-2000 would be my most specific example of where we're trying to—that one would be more raising the ceiling, but where we're involved with codes and standards.

Mr Brownell: How long has your alliance been—

Ms Oliver: Over seven years.

Mr Duguid: My questions are along the same lines. You talked a fair bit about codes and standards; you talked about building codes. Were you referring to building codes for residential to be built in the future? Is that what you were talking about?

Ms Oliver: Yes. I think there is also place for renovations, but I was specifically referring to new builds. There's also room for opportunity in renovation codes, but very specifically I'm talking about new technologies, new appliances, new buildings, whether they be residential or industrial.

Mr Duguid: What kind of improvements would you be looking for?

Ms Oliver: Which? Sorry.

Mr Duguid: What kind of improvements to the building code and standards would you be looking for?

Ms Oliver: I guess just more airtight buildings that would be more energy-efficient, improvements in furnaces and different things. I couldn't speak specifically because the person who deals specifically with codes and standards is not with me. I apologize. I can take any questions on that front and get back to you with a more in-depth response.

Mr Duguid: Do you have any idea in terms of codes and standards for built housing? How would you address that problem?

Ms Oliver: I couldn't speak to that directly, but again I can provide you with a response, if you like.

The Chair: Thank you, Fiona. You will then provide us with a list of the members of the alliance?

Ms Oliver: Yes, and response to the comments.

The Chair: You can do that in short order?

Ms Oliver: Yes.

The Chair: Thank you for attending. We appreciate that.

This meeting is now recessed until 4 o'clock this afternoon.

The committee recessed from 1206 to 1602.

CANADIAN FEDERATION OF INDEPENDENT BUSINESS

The Chair: We can call back to order, ladies and gentlemen. Our next delegation is the Canadian Federation of Independent Business, Judith Andrew and Satinder Chera. Would you like to come forward?

If at the start of your presentation you could introduce yourselves and the organization you're from for the Hansard record as well, that would be great. Each delegation has been allocated 20 minutes. You're free to use that any way you like. If there is any time left over at the end, we'll be using that for questions. That time will be allocated amongst the three parties.

Ms Judith Andrew: Thank you, Mr Chair. I'm Judith Andrew, vice-president, Ontario, with the Canadian Federation of Independent Business. I'm joined today by CFIB's Ontario director, Satinder Chera. I appreciate the opportunity to appear today and, first, would like to congratulate all of you on your election. I haven't had a chance to do that personally. It's nice to have this early opportunity to appear before a committee of the Legislature.

We have distributed a kit for your information today. The presentation I'm going to speak to is in the left side of your kit. The right-hand side of your kit contains some useful information, including CFIB's Ontario Small Business Primer for 2003, an information piece that we've been circulating to our members dealing with electricity and our efforts to give input to the process dating from considerably prior to the market opening in 2002, and a short report dealing with the impact of the power blackout in August of this year.

For our agenda today, I'd like to give you a brief glimpse of small and medium-sized enterprises in Ontario, who they are and why they're important; and then talk about meeting the future energy needs of the small business sector, what we feel we've learned from the past and what can help with planning for the future; and make some comments about Bill 4 and whether indeed it meets the needs of small and medium-sized enterprises, or SMEs, as they're called.

Page 3 of the presentation shows the profile of Ontario's business sector. As you will see, the profile shows that it is overwhelmingly small businesses that make up Ontario's business sector. Almost three quarters of the

firms employ fewer than five people, and 95% of businesses in this province have fewer than 50 employees.

Page 4, entitled, "It's a 'Small Business' World After All," gives some breakdown on how the employment is distributed among businesses in Ontario. As you can see, small and medium-sized businesses, which are the two blue parts of the pie, show that businesses employ more than half of workers in Ontario. So SMEs are the predominant employer in the province.

The next chart shows some history since 1991 dealing with job creation in the province. In 2002, of the 196,000 jobs that were created in this province, nearly 85% were created in small and medium-sized business enterprises. The history—the blue bars are the small business share—shows that our sector provides a lot of resiliency in periods of economic recession. They attempt to hold on to their valued employees, rather than shedding jobs, as happens in larger players in the economy.

The next page deals with our own membership. If anyone thought that we were predominantly retail or a particular type of business, that certainly isn't true. Ours is a very diverse group. We have large numbers of manufacturing, construction firms, services, and really are a diverse representation of the business population in the province.

With that brief opening, I want to turn to some issues around meeting the future needs of the small business sector in the electricity arena—first, the need for fair and consistent policies. On page 8 you will see some data dealing with a study we conducted after the market opened in 2002. In fact, the study results were delivered in the fall of 2002, about a year ago. The May 1 market opening and the hot summer actually produced high prices, as many of you will recall, and that was certainly borne out in our survey results. Those summer prices hurt small and medium-sized businesses.

This past summer, in August 2003, the blackout cost our sector somewhere between \$1 billion and \$2 billion. The full study is in your kit, as I mentioned. The impacts were many and important. In terms of the power blackout and its aftermath, many firms had employees unable to work. They lost production; they lost orders and sales; there were a variety of difficult impacts for small business to deal with.

The market opening produced not only fluctuating prices, but there were also formerly hidden charges that became visible in the businesses' unbundled bills. So when we asked our members, "Have you encountered any new or significantly enlarged fees associated with the new electricity system?"—other than the debt reduction charge, which everyone was complaining about—a big chunk of our members had made note of new fees and charges.

As for security deposits demanded of them by the local distribution companies, the former utilities, the survey finding was that roughly two thirds of the respondents said no to the question of whether that deposit was geared to their firm's creditworthiness. There were clearly problems on these kinds of side issues but nevertheless very important issues for our sector.

1610

Now a word about energy conservation and demand management. We certainly know that in the short term, CFIB members are able to take measures to reduce power consumption, because they did so after the blackout. They did all the things that were asked of Ontarians: reduced air conditioning, lighting, office equipment, business operations. In some cases, they shut down or had all their employees stay home. Despite taking a hit of \$2 billion across the Ontario economy, small businesses certainly did their part to help conserve in those days after the blackout.

The next page, page 12, deals with some other tools for demand management. We've asked in a couple of different ways about the use of metering, interval metering and the like. We found that our sector had a lot of trouble getting anyone to pay any attention to them in terms of giving them these sorts of tools to manage their use of electricity and essentially take charge of the commodity usage. We figure, based on our results, that about one fifth of the respondents say they can't use a meter of some type, but the other 80% really haven't got an opportunity to use those tools.

Page 13 deals with something else, which may seem a side issue to the whole thing, but it's the bill. Essentially, education on one's usage and understanding one's own consumption patterns and managing them and helping with conservation starts with the bill. Most of our members prefer a more simplified, easily understood bill. We made these points within the former government's review, undertaken by consultant Salvatore Badali. Mr Badali made it clear in person with us and in his report that his recommendations would apply to small and medium-sized enterprises. We don't believe the Ministry of Energy or anyone else has put a lot of effort into applying Mr Badali's recommendations to small and medium-sized enterprises. He called for a review of the fixed and variable charges. Small businesses obviously need to know what is fixed, what is variable and what they can actually control on a day-to-day basis. That is not apparent in the bill.

Looking now at meeting Ontario's long-term electricity needs, about a year ago we asked a number of questions about what our members felt would help offer secure, reliable power at the lowest possible prices in Ontario. There are a number of issues canvassed there. I think the key thing that one can take from this survey is that this time around, in terms of electricity industry reform, the interests of consumers and not the industry players must be the top priority.

Page 16 contains some finding dealing with the Ontario Energy Board. CFIB certainly supported the passage of Bill 23. The changes therein give ordinary Ontarians a bigger voice in shaping the future of Ontario's electricity market. We certainly look forward to participating in consultations on the future rate-setting regime. The energy board needs to respond to consumers, and not in a way that really makes it the preserve of experts and consultants whose only business is to appear before the

energy board. We're making the case that this time around, the programs and services need to be tailored to the needs of small and medium-sized enterprises and, for that matter, the small consumer. There must be real choice and just-in-time information to allow small consumers to take responsibility for the electricity they use. Our finding in the prior survey was that there wasn't really much happening in terms of choice, and in fact most businesses remained under the standard supply service with their former utility.

Tying this all into Bill 4, does Bill 4 meet the needs of small and medium-sized enterprises? Certainly when we had meetings with the minister and officials recently, we've argued these points: the need for fair and consistent policies. The key market players—the Ministry of Energy, the Ontario Energy Board, the local distribution companies—must respond to small and medium-sized enterprises on things like charges, security deposits, billing formats, information and resources. These are not small issues, but in some respects, they're put to the side and nobody deals with them directly, but they feed right into the energy conservation and demand management challenge. So that's a big X there, because nothing really has been happening on that front, and in fact the local distribution companies have been granted an increase and an ability to recoup prior costs, and there's not a specific direction for small and medium-sized business.

On the energy conservation and demand management front, we are arguing that small businesses, which account for a big chunk of the power consumption in the province—we were told, at one point, nearly half—should be given the tools to manage and conserve electricity, whether it's metering or other approaches. They need those tools to be able to keep control of this cost item. The rate change itself—when the former government brought in the 4.3-cent cap on rates, this was really the first time anyone had paid attention to small and medium-sized business. I know it's universally felt not to have been a good policy, but frankly, we need transitioning out of this by April of next year, to have some good directions for small and medium-sized business, because it will hurt, with the increases happening and small businesses not having an ability to manage it.

Finally, in terms of meeting Ontario's long-term electricity needs, we are supporting and I think other groups are supporting as well a new market arrangement that allows low-volume consumers some protection from the uncertainty and volatility of the spot market. This could be through contracts for future supply which would support the financing for them. Part of this involves mitigating the dominance of the big generator in the province, OPG; obviously, tax incentives for alternative sources; distributed generation. They are all pieces of the puzzle, but it is clear that what was most problematic about the May 2002 market opening was that small consumers were exposed to the volatility of the spot market directly through the pass-through, and that did not help. So that's a big question mark, and we urge policy-makers to address that.

We would be pleased to attempt to answer your questions.

The Chair: Thank you very much for your presentation. We've got about five minutes left. We'll start with the government side, then move to the Progressive Conservatives and then on to the New Democratic Party in this rotation. Brad?

Mr Duguid: We have five minutes left for all of us?

The Chair: I'm afraid we do, yes.

Mr Duguid: OK. I'll just ask a quick question, then. I was looking at page 19, the need for fair and consistent policies, and I didn't quite get specifically what you're referring to. Are you referring to this particular bill, that there are some unfair or inconsistent policies within this bill, or were you referring to energy policy as a whole?

Ms Andrew: This presentation is a broader presentation dealing with energy policy as a whole. I know that when the 4.3-cent cap went on, we weren't expecting that to remain in place forever; I don't think small businesses were. But transitioning out of it, we need to have policies that address these issues. It's not simply a question of consumers paying something closer to the cost. I know that raises \$700 million and is beneficial from the standpoint of the provincial deficit, but that's not where it ends. We need to have these other policies as well.

Mr Duguid: Just very quickly, does CFIB have a policy in terms of encouraging or discouraging governments from running deficits?

Ms Andrew: Our members are very strong in terms of governments running deficits and debt. They see those as tomorrow's taxes. So it is very important to address the \$5.6 billion. I suppose there might be some debate on how that should be done. We're not disagreeing that there needed to be changes in the electricity arena, but these issues that will provide an appropriate transition to a new regime must be addressed; it cannot be just a price increase without anything else.

1620

The Chair: Michael, do you have a brief question?

Mr Michael Gravelle (Thunder Bay-Superior North): Just as to what your thoughts are, Ms Andrew, in terms of—once the fixed rate was put in at 4.3 cents, this \$800 million obviously has been the cost. Did the CFIB take a position on that? That was a clear cost to taxpayers in terms of the real cost of electricity.

Ms Andrew: The 4.3 cents, of course, was presented as being self-balancing, in the sense that the market power mitigation agreement was supposed to produce a fund that would even out over the long term. That's what we were told. We now are told that that's not the case. Our members don't want to see the electricity system subsidized by taxpayers. Our members, when we asked them about the debt, opted for ratepayers to pay it. It's almost the same thing, of course, but still an important distinction.

The Chair: Kim, do you have a brief question?

Mr Craitor: I sat on the chamber of commerce for 10 years as the city representative, so I'm accustomed to working with small businesses. It doesn't sound like

you're opposed to the bill; it sounds like what you're saying is you're looking for some kind of a transition for small business. What is it? What's the transition that you're looking for? Just tell me what it is.

Ms Andrew: Hopefully by April 1 there would be some clear direction to address these issues. The extra charges are all over the map. The terminology for items on a bill is quite varied. The Badali report got into all of the deficiencies. There is a small pilot project going on in Hamilton to address these in respect of residential consumers, but no one is paying attention to these billing issues for small business. The LDCs have made the case for more money, but they're really not moving on these. So we would argue that the government should insist that the LDCs address these things to their satisfaction.

Mr Craitor: What do we do, bundle them back up again?

Ms Andrew: No, there needs to be some revamping of the bills so that the fixed costs are evident, the variable costs are evident, there isn't such a widespread difference in the terminology so that people can understand what their bill says—there are a number of things that kind of sound small, but they are big irritants and big concerns when it comes to a small business owner who wears many hats trying to focus on managing this piece of their bottom line which they never really had to manage before.

The Chair: Thank you. I'm afraid our time is up. We didn't get to questions from the other parties, but we are changing the rotation.

Mr Jackson: That's quite unacceptable.

The Chair: It may be unacceptable. I thought we established the rules at the start. We can go on forever if you like. How long do you want to stay here?

Mr Jackson: I think the rules were established with a higher degree of fairness and efficiency in the Chair. That is essentially the point. You started by saying it would be divided equally among the three of us, and then you proceeded to, "Are there any further questions? Are there any further questions?" That's transparent, Mr Chairman. If you're going to be fair, be fair.

I hasten to add, Mr Chairman, that we have someone who even has indicated they are not in favour of a substantive part of this bill, and you're not allowing the opposition to ask the questions. That's fine. If that's the way you're going to run the committee, that's fine.

The Chair: I think that's a little unfair, Mr Jackson.

Mr Jackson: No, I clearly put on the record what happened.

The Chair: This morning I went out of my way to be fair to you, I think, in the time. We exceeded the time limit. I went out of my way to prove that I was going to be a fair Chair.

Mr Jackson: Is the next deputant here? Are the next two deputants here in the room?

The Chair: The next one deputant is here.

Mr Klees: I'd like to speak to this, Chair. On a point of order: With all respect, I'd like to speak to this as well. In all the time that I have ever been a member of a

standing committee, sir, never before has there been this kind of allocation of time. It has always been understood that whatever amount of time is available at the end of the presentation, that time would be divided equally unless it is set out prior to the hearing commencing that there would be a rotation.

I just leave that with you. I realize it's the first time in the chair for you. I just want you to understand that that has been the precedent.

The Chair: I apologize for not being clear this morning. I thought we had set out that rotation.

Mr Peter Kormos (Niagara Centre): Mr Chair, if I may speak to that point of order: With respect, Chairs have shown a great deal of flexibility in the course of utilizing the remnant of time, the balance of the 20 minutes. From time to time it's so short that it can't be meaningfully shared. Chairs will say, "This time around it belongs to the government"—it used to be the Tories, right? "This time around it belongs to the official opposition. This time around it belongs to the New Democrats." So I have no quarrel because, as I understand it, you were democratically elected by this body. I understand it was an acclamation, so clearly members of this committee expressed their support of you, their confidence in you, upon your election. This is only your first day chairing a committee.

Cut the Chair some slack. He's showing good judgment and, after all, you chose him democratically. Support the man you put in the chair.

The Chair: I think we're starting to have a little bit of fun here.

Michael?

Mr Gravelle: I'll let Ms Wynne go first.

Ms Wynne: I was just going to make a suggestion. Instead of spending the next 10 minutes having this delightful exchange, could we possibly—because it looks from the agenda like there is some time at the end; we don't go right to 6 o'clock, as far as I can tell—ask the people who are next if they would mind giving us another five minutes and letting the opposition members ask their questions? Would that be possible?

The Chair: Ms Cutler, would you mind that? OK, if that's the pleasure of the committee. Michael?

Mr Gravelle: I think it's a great idea, Mr Chairman, just in terms of defence—and Mr Kormos is quite right, and Mr Klees should know this, and he does know this: When this situation occurs, it's not uncommon at all for the Chair to decide that one party will get their turn that time, with a short period of time, and it's made up to the opposition or the government next time. That happens frequently in committee.

Mr Jackson: I'm not arguing that, Mr Chairman. The Chairman said, "I'm going to rotate this five minutes between the three." He said that. It came out of his mouth. That's my objection.

Mr Gravelle: We're trying to come to a conclusion. I think Ms Wynne has come up with a lovely solution.

The Chair: OK, if you have questions—

Mr Jackson: If you're going to say it, then do it. If you're not going to do it—

The Chair: Cam, I did say it. Maybe you didn't hear what I said.

Mr Jackson: I heard exactly. That's why we have Hansard here.

The Chair: Well, we can go back to it.

We have a delegation before us who wants to give us some information. It is the pleasure of the committee that those questions be asked, so we're going to extend it for a period of time.

Mr Jackson: Ms Andrew, welcome. Thank you for your presentation. Can you indicate, do your members support the \$140 million that businesses predominantly and consumers particularly are paying for the GST on the debt service charge?

Ms Andrew: We haven't surveyed directly on that one—

Mr Jackson: This isn't a big stretch, right? What would your answer be?

Ms Andrew: —but we've had a lot of comments complaining about it.

Mr Jackson: My next question is, has your membership guided you in terms of issues around the security deposits? You've eloquently placed on the record that everything in this bill is stacked in favour of the LDCs. Interestingly enough, they're not making a presentation to this committee to respond to the issues. But we also found out this morning in committee hearings that the LDCs are now in a position to make yet another application to the Ontario Energy Board once this bill takes effect. So they'll be paying three cents on the old application, which is \$750 million, a quarter of a billion over four so they can guarantee their profit at two cents, and now they're going to be allowed to go back at the membership again. Your concerns—have you got a more substantive list of changes you were seeking to balance out the kind of wholesale capitulation to the agenda of the distribution companies?

Ms Andrew: We would like to see an implementation of the Badali recommendations in small business. We've made strong submissions on an OEB committee dealing with security deposits. That's been a very hard-fought committee. I could certainly supply this standing committee with copies of our recent submission, but we're now haggling over whether the LDCs will retain a deposit for up to seven years, which seems a very long time. I think a bankruptcy can be excused after a period of time like that.

Mr Jackson: I might yield some time to my colleague, Mr Chair.

Mr Klees: Thank you for your presentation. You no doubt have done some analysis of the implication to your membership, the small and medium-sized businesses in Ontario, during the transition period, where there is protection for residential users, effectively, but there's a major exposure to the small and medium-sized businesses. Can you share with us what your analysis has shown in terms of the potential impact to this very important sector of our economy?

1630

Ms Andrew: We're actually about to do that analysis, Mr Klees. We know that 150,000 per month will not go very far in most small businesses. When we argued for an increase of the 150,000 kilowatt threshold to 250,000 kilowatts, we had a lot of members calling us or writing us frantically, saying how desperate they were to have some rate relief, so 150,000 kilowatts per month won't go far at all. That's why we're very serious about seeing some concrete measures in place before April 1 next year.

Mr Klees: I think the caution to the government on this is that there will be serious consequences. We went through this when we put the mitigation in place for small businesses the last time around. There was a reason for the cap. The reason for the cap was that during the transition period it would provide protection for small business. I think it behooves you to ensure you get that information in to the government sooner than later, because what we don't want is after the fact, when those bills start rolling in, when small and medium-sized businesses can't pay their energy bills, which is guaranteed it's going to happen. Better that the government has a heads-up in advance, and hopefully they'll listen to ensure those protections are put in place while this exit strategy is being worked out.

The Chair: We still have a minute left. Mr Kormos?

Mr Kormos: Whoa, whoa; wait. How many minutes did you allot to that slot?

Interjection.

The Chair: The committee agreed to extend the time. Probably, if you asked a question, the Chair would exercise some latitude, or you and I could argue about it. I'd prefer to hear the question.

Mr Kormos: I feel abused. Ms Andrew, it's always a pleasure. Do you share my sense of irony? Here we are in this committee discussing this bill, and what's plugged into the wall but an energy hog, an electricity pig, an electronic space heater, one of the most inefficient ways of producing heat that's ever been concocted and one of those real drains on scarce electricity supply. I can't for the life of me think why this government wouldn't be more committed to demonstrating how to do it, rather than just talking about it.

The Chair: Thank you once again for attending.

Let's get this clear before we have our delegation up here. Last night at the subcommittee meeting we agreed to some rules. Obviously those rules aren't working. People are taking a good portion of their 20 minutes to make their presentations, which is leaving very little time for the questions. Before we bring somebody up here, is there any desire to change those to extend that period of questioning?

Mrs Cansfield: What I might suggest is that the Chair have some flexibility and discretion and in essence wing it a little. Some of the presentations were really about 13 minutes, and then you had some time; others were only seven or eight, and then you had more time. If in fact the presentation takes that 15 or 17 minutes and it leaves

little time, then I'd use your discretion to ask the next person for the leeway of another 10 minutes; if not, stick to the rules. It just permits you the flexibility, Chair.

Mr Jackson: I'm a big fan of flexibility, partially because, as we know, people get caught on streetcars or subways or by the weather or in traffic or a dozen other reasons. Second, when you tell a deputant that they have 20 minutes, it would be helpful to the committee if you could confine that to no more than 15 minutes, leaving time for questions etc. For many people this is the first time they've been in the building, let alone present to us. That still gives you some flexibility. I have no problem with the rotational rule. I do have a problem that people have come a great distance to present to us, and they're deserving of some feedback other than something they could have sent in the mail.

Mr Kormos: The Chair is doing his best. It's his first day as Chair of the committee. Cut him some slack. These things shouldn't be discussed on the record. Let's deal with them in camera after midnight tonight.

The Chair: He's my new friend.

Ms Wynne: I would just suggest that I think it makes sense to share the time. If it's a short time, whatever you determine the time, I suggest that you do share it among the three—

The Chair: The problem I've seen is that we've been sharing six minutes. Some of the questions have been taking more than two minutes to ask.

Are you still glad you came, Ms Cutler?

Ms Judy Cutler: I'm fascinated. I'm wondering how you ever get anything done.

CANADA'S ASSOCIATION FOR THE FIFTY-PLUS

The Chair: OK, Ms Cutler, thank you for coming. Could you identify yourself for our Hansard. We're finding with the microphones that if you don't speak directly into them, Hansard is picking up some gaps when you turn your face away from them. You have 20 minutes. Apparently I have some latitude and flexibility, but if you would leave some time at the end for questions; there appear to be more questions than time.

Ms Cutler: I think I'll be brief.

I'm Judy Cutler. I'm director of communications and co-director of advocacy at CARP. Thank you so much for this opportunity to express our views today.

Let me just begin with a few words about CARP for those who don't know us. We're Canada's Association for the Fifty-Plus, a non-profit organization with more than 250,000 members in Ontario and 400,000 right across the country. Our mission is to promote and protect the rights and quality of life of older Canadians. Our mandate is always to develop practical recommendations for the issues we raise. We like to say we don't just carp about things.

Given the short notice that we had to prepare this presentation, and our limited expertise in the area of energy and electricity, the message I'm bringing to you

today is based on our very deep and serious concern about the impact of your amended act on poor and low-income seniors. Although there are many other Ontarians who should be given the same consideration, today I'm speaking on behalf of older citizens.

Bill 4 is limited to situations defined with respect to amounts of electricity used and times when electricity is used. In our view, this should be extended to include differential fees for poor and low-income seniors who can come under the category, we suggest, of "designated consumers." In other words, our recommendation, and indeed our request, is that you create differential fees for poor and low-income seniors—not a rebate or tax credit, but a lower price, pure and simple.

It's essential that we as a society, and you in particular as the government, of all Ontarians recognize the realities facing many seniors. Poor seniors actually account for 16% of all Canadians. Poverty affects their physical and mental well-being and in the end creates a financial burden on our health care system.

What about quality of life? Let's go beyond the usual silos that exist in government and communities with a more holistic or integrated perspective in terms of the needs of seniors.

Inadequate pension levels do not keep up with real inflation but are based instead on a very unrealistic formula. More and more seniors, not only those who are homeless, are having to access food banks. There's a lack of affordable rental housing; there are increasing user fees in the health care system, including for prescription drugs, especially for those not on the formulary.

Recreation, continuing education, transportation, telephone, cable, all these things contribute to quality of life but are not always affordable for seniors. Too many of them are already having to choose between eating properly and taking adequate medications. We have to recognize that everyone has to pay rent, property tax and hydro, but the other essentials are often left out. The truth is, even though we hear otherwise in the ageist myths around, that only 5% of seniors are rich enough to be clawed back entirely in their public pensions.

1640

Many seniors tend to remain at home, either by choice or by condition, and they're not in a position to lower thermostats at the suggested times without endangering their health and well-being. Forcing them to do so can result, again, in increased costs to the health care system.

Do we know that these people will be able to limit their consumption to under 750 kilowatt hours per month at any time? Shouldn't we undertake a study first to find out, before we impose this on them? It's important to note that many seniors—I suggest most seniors, actually—can't afford to invest in more effective and cost-efficient furnaces and appliances. In fact, government grants, not loans, for this purpose should be made available in such cases.

Many seniors are paying very high rents, up to 80% and even 90% of their fixed income. Their rents may or may not include charges for electricity. Either way, tenants could be paying more out of their meagre incomes.

Findings of a recent Stats Canada study show that many seniors own their own homes. However, as with many farmers, all this could mean is that they are asset-rich and cash-poor. They've lived in their houses for many years—30 or 40—during which time they've paid off their mortgages. But their property taxes and other living expenses have increased, as we all know, and often well beyond their retirement incomes, whether private, corporate or public pensions. Their incomes are fixed and, in many cases, even greatly reduced because of current market conditions.

Unlike non-seniors—except for children, of course—seniors generally are unable to earn sufficient additional income, even if they do return to work, and that is not easy to do.

Who are the seniors we're describing? Poor seniors can be identified through the guaranteed income supplement, the GIS. They represent 40% of all seniors identified by Ottawa as having incomes below the low-income cut-off line, which is about \$16,000 for singles and about \$24,000 for couples—not very high. The largest percentage is women, with annual incomes of around \$13,000, derived from OAS, GIS, Gains and perhaps a widow's or survivor's benefit, but of course men are included in this too.

The Ontario government actually identified poor seniors when it introduced the two-tier charges for prescription drugs for seniors covered under OHIP. This was made possible because Ottawa provided the Ontario Ministry of Health with the appropriate list, which is permissible under the privacy provision of the GIS regulation. Low-income seniors can also be identified. The greater Toronto council did that when it exempted them from property tax increases caused by actual value assessment.

So CARP strongly recommends the following: Amend the bill to include poor and low-income seniors in the category of designated consumers. Charge these seniors the current basic price of 4.3 cents per kilowatt hour, regardless of usage or time. Develop plans for conservation by seniors, taking into account health implications and impacts, as well as other specific conditions. Create government grants to enable seniors to take conservation measures. Commission a study to determine electricity usage patterns of seniors. For example, when the energy minister, Dwight Duncan, said that approximately 60% of Ontario households use less than 1,000 kilowatt hours per month, does this apply to seniors?

We would like to see this government being senior-friendly in all areas, and this is certainly one way to start and a step in the right direction. Thank you.

The Chair: Very good. Thank you, Ms Cutler. You used up eight minutes, which would leave 12 minutes to be split evenly, so why don't we make that five minutes each? We'll start with the Progressive Conservatives, move to Mr Kormos and the New Democrats and then move back to the government side. Everybody's happy.

Mr Jackson: Judy, thank you for coming today on short notice. As someone who has worked with CARP

ever since it was formed, please give my best regards to Lillian and to Murray and the rest of your crew down there.

Ms Cutler: I will.

Mr Jackson: You have presented and captured the essence of the concerns, and that is that this bill is about increasing the price and bringing it closer—it's still got a cap, but it's bringing it closer to what the government refers to as the actual cost of electricity. You've indicated that there isn't a kind of consumer protection in this bill.

My question to you is: Have you given some thought as to how we could designate and identify lower-income seniors for purposes of adjustment on their bill?

Ms Cutler: Yes, I thought that I had stated that clearly. You can do it through HRDC, in terms of people who are getting GIS, for example. That would cover a lot of people.

Mr Jackson: But you're suggesting that the price be less as opposed to a rebate?

Ms Cutler: Yes, just because these people don't have the money to put out and then wait for it to come back.

Mr Jackson: Are you aware that this bill changes rather dramatically the costs being borne by consumers and small businesses, that it doesn't include the half of the energy grid which is going to industrial users?

Ms Cutler: Yes, I am.

Mr Jackson: You are aware of that. OK.

This morning, the minister was asked at least one question with respect to the cohort that you've identified today: low-income and poor seniors. His response, and I paraphrase and I encourage you to seek a copy of Hansard because you'll get the exact quote—his reference was that “In these cases family members are going to have to pitch in,” was the words he used, and that “there are other charitable organizations and other groups in the community that might be called upon to help out.” Is that how you envisage that being helpful at all to those seniors who are living at or below the poverty line?

Ms Cutler: No, not at all. I think families are already burdened in terms of helping their loved ones with home care, with nursing homes, with all kinds of things. It's just shifting the load to another part of the elephant, so to speak. It's not dealing with the situation at all.

Asking seniors to find organizations to help them is demeaning, for one thing, and it's putting a burden on them that they may not be able to deal with. We already know how hard it is for people to access things that do exist because they don't know where to go. This is just creating more stress.

Mr Jackson: Your organization is very sensitive to the basket of costs that a senior has to confront. You've identified many of them in your presentation. Concern has been expressed by organizations like yours that in the first two weeks of this government's mandate, we have seen a repealing of the seniors' property tax credit which applied to seniors in apartment buildings to reduce approximately one quarter of the cost of the property tax as in the form of rent or in their properties. You've identified seniors who are house-rich and income-poor

and can barely make ends meet without being forced out of their home.

The second bill is the energy one. The third one that's coming down the pipe is the income testing of the drug plan and the bold statement that they need to recoup about \$2.2 billion in the seniors' drug plan.

In your view, do you feel that the government should at least, out of those three, be trying to make some amendments to this act to protect low-income seniors, given that they're not protecting them by repealing their tax credit and rent credit and because they will be proceeding with the income testing of their drug plan?

Ms Cutler: Well, we've been told that the income testing is not a—I'd love to find out, because we keep hearing about it, but I've been told by several ministries that it's not happening, so I hope we're not being lied to. We were actually against the education tax rebate. We would much rather see that money go into home care, which your government promised—and so did yours—and we're waiting to see what's happening, because so far nothing is.

Home care is in dire straits. If we have to wait very long, we won't have a home care system. Nursing homes are in dire straits, and people are in nursing homes who could be at home if they were given proper home care. If you're announcing something that is being taken away, at least explain that the money will go to something else that is perhaps more important, like the education tax rebate being used to go into home care, for example.

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Mr Kormos: Thank you, Ms Cutler, for coming today. A good submission, a valuable submission. I want you to let your membership know that they've been well served.

This morning, Mr Duncan—he's the minister—was in here and he again talked about how when you shield consumers from the true cost, you encourage consumption instead of encouraging conservation. I hear him, but the seniors I know—down where I come from, Welland, Thorold, Pelham, south St Catharines, Port Colborne, places like that—have cut to the bare bone already. They've got the 25-watt bulbs in instead of the 60s. Is that a pretty accurate perception? Have I somehow got some sort of unique group of seniors down there, or is that pretty reflective of the whole province and seniors in general?

Ms Cutler: Yes, seniors have cut back, partially because they can't afford it and partially because they have a sense of value in terms of doing that. But I think that a lot more could be done, as I said, in encouraging them and providing funding to allow them to transform to conservation appliances and all kinds of things; also an awareness program of what they can do to conserve more energy.

We just keep hearing, “Conserve, conserve, conserve.” How? What do I do? Do I just turn the lights off? Do I stop cooking? Do I sit in the cold? Obviously we know that there are other ways to do it, whether it's in the summer with air conditioning or in the winter with heat-

ing. The government should have a really good awareness campaign that CARP can actually help with in terms of developing and also disseminating in our magazine, on our Web site. I'm sure that all the seniors' groups, through the seniors' secretariat, would be willing to do the same thing.

Mr Kormos: You made reference to the fact that seniors don't have some of the same flexibility around reducing electricity. I mean, gosh, I certainly don't want to speak for all seniors, but my old grandmother, it'd be 80 degrees and she'd still be cold. That's just the nature of it. You can't expect seniors to do some of the things that you can expect you and me to do in terms of turning the thermostat down to 65 and stuff like that, can you?

Ms Cutler: No, you can't. I'm going through an experience now where I look after my brother. When I leave my home, I turn the thermostat down. When I go to sleep at night, I turn it off. He is not well; he can't walk. He's lying in bed; he's not moving to keep the juices flowing. I can't ask him to sit in a cold room with the lights off. So I don't know. Hopefully it's temporary, but meanwhile, I've got to be compassionate. I can't say to him, "You're wasting energy." We have to be a little flexible in terms of specific needs.

Mr Kormos: OK, the final thing: I simply want to apologize to you, because you indicated that you were given short notice and that made it difficult to prepare. Trust me, we did our best to keep the time allocation motion—so I apologize.

Ms Cutler: I wasn't complaining; I was just pointing it out.

Mr Kormos: But it's difficult. People work so hard and then governments do things like restrict public hearings and give such short notice.

Ms Cutler: Well, we're very happy to be included, and if that was the price to pay, we're happy to pay it.

Mr Kormos: I know. You shouldn't have to jump through hoops. You did; I appreciate it very much.

Ms Cutler: Thank you.

Mr Kormos: Thank you kindly.

The Chair: Donna, you had a question.

Mrs Cansfield: I had two questions. I just wanted to ask, when you refer to seniors, what age are you referring to? Are you just referring to everybody 50-plus or a specific age?

Ms Cutler: Our membership is 50-plus. I guess I'm referring to older seniors who tend to be frail. When I talk about 50-plus, I'm referring, I guess, to the families who are looking after their loved ones.

Mrs Cansfield: That's fine. I just wanted to understand.

The other was that you spoke about an opportunity to identify those who might in fact benefit from a subsidy or a word of that description. Currently, there's in place a rebate for your taxes; I think it's up to \$1,000. Could you use that same sort of mechanism, do you think, to help in terms of finding a way other than through a federal means test? That is a provincial formula that's in place now. Have you looked at those—

Ms Cutler: Are you talking about the formula or the idea of a rebate?

Mrs Cansfield: Both actually. I'm looking for a mechanism, and since we already have a mechanism for the tax rebate in place, could that type of formula be used? Because it's based on income.

Ms Cutler: We're really against the idea of a rebate because people still have to come up with the money at the beginning, and if they are living on a fixed income, that's not very easy for many of them. That is one idea. What we would like to see is a round table, a consultation with seniors' groups, so that something very practical for both sides can be developed instead of assuming that we already have all the options. Something that's more viable for the government and practical for seniors could possibly be developed that way.

Mrs Cansfield: I just share with you because it was this morning and not this afternoon when the minister was here, but he made a very strong commitment that there will in fact be a very comprehensive approach to energy conservation that will be very inclusive in dealing with consultations. He'll announce something very shortly and that will occur in January and onwards.

Ms Cutler: Oh, great. I just add that I really am serious when I talk about a senior-friendliness. Ontario can lead the way and should lead the way in the country. I think we have a really good minister responsible for seniors, and I would just like to see him and his ministry being involved in policy in other ministries to make sure that seniors are considered.

Mrs Cansfield: Thank you. I think that applies to so many ministries: education, environment—

Ms Cutler: Every one. There is hardly any actually that—absolutely.

Mrs Cansfield: I think some of us have a vested interest; we're seniors too.

Ms Cutler: If not, we'll all get there, right?

Mrs Cansfield: We are there.

The Chair: Kathleen, do you have a question? We have about three minutes left, two and a half minutes.

Ms Wynne: I raised this issue this morning, actually, with the minister for seniors, particularly tenants. But as I read the act—I just want to be clear what you're asking—the designated consumers, as it's outlined here, it seems to me it's payments. It's sort of a rebate to those people, but that's not what you're asking for. You don't actually just want to be included in this category. You want it to be arranged differently.

Ms Cutler: To be included and taken a step further.

Ms Wynne: Right, OK. When you're talking about poor, are you talking about seniors with a Gains certificate, who can produce a Gains certificate? What's the threshold? The asset-rich poor senior—that was the situation I raised this morning with the minister, the widow living in the big house who was on a fixed income and couldn't afford to retrofit her house or whatever. How are you defining poverty?

Ms Cutler: We're talking about those below the cut-off line obviously, and they can be identified through

GIS, for example. We're also talking about low-income seniors, many of whom, for example, are having to pay the equivalent of two rents because they're paying their own rent or property tax and a nursing home fee for a spouse. Low-income people have as many expenses as higher ones do, with less income to pay for it. We have to do it including the low; I'd even include modest. There has to be a study to determine where that line is because there are so many things to consider in a holistic way in terms of having to pay for home care and nursing homes, all of that.

Ms Wynne: So probably a simple amendment of this bill is not going to do it. Probably the round table and what Donna was referring to is what needs to happen because we have to have this conversation about vulnerable seniors across a bunch of fronts.

Ms Cutler: I would like to see a round table, a consultation process with Minister Gerretsen and other ministers who are dealing with issues of concern to seniors to develop a package that goes right across the board and that is interrelated, so it isn't taking from one and giving to another and they end up with nothing.

The Chair: Thank you, Judy. It was a pleasure to have you here today.

Ms Cutler: Thank you so much.

1700

ONTARIO FEDERATION OF AGRICULTURE

The Chair: We can move on then to the next delegation, and that's the Ontario Federation of Agriculture. I understand that Ron Bonnett and Ted Cowan are here. Do you have any idea of the approximate length of your presentation?

Mr Ted Cowan: About two and a half or three pages, so that might be 1,000 words.

Mr Ron Bonnett: Might be in that neighbourhood.

Mr Cowan: Approximately 1,000 words or 1,200 words, something in that neighbourhood.

Mr Bonnett: Do you want me to count fast? Is that what you're saying?

The Chair: No, I'm just trying to establish the rules so we don't spend time arguing while we should be asking you questions.

Mr Bonnett: OK. Good enough.

The Chair: Do you think your presentation will be under 10 minutes?

Mr Bonnett: Oh, yes. I think I can keep it under 10 minutes.

The Chair: OK. Why don't we hear the presentation and go through the same rotation again, with five minutes for each of the parties.

Mr Kormos: I'm going to try to use all my five minutes.

The Chair: You didn't. I noticed you used four. Apparently, you can't bank the time, though.

Welcome. Would you identify yourselves also for Hansard. You'll find that you need to speak directly into the microphones.

Mr Bonnett: Usually I don't have trouble being heard. My name is Ron Bonnett. I'm president of the Ontario Federation of Agriculture.

Mr Cowan: Ted Cowan. I am with staff at the Federation.

Mr Bonnett: First of all, I'd like to thank the committee for taking the time to hear our views on Bill 4, the Ontario Energy Board amendment act on electricity pricing.

For those of you who don't know, the Ontario Federation of Agriculture represents about 40,000 individual farm families across the province, as well as a number of commodity organizations. We advocate on their behalf and on behalf of rural Ontarians to secure a sound, workable energy system and marking pricing.

Farmers rely extensively on technology, which in turn requires a dependable and affordable source of electricity. In the interest of positive progress and building and improvement in the agricultural and rural sectors, the OFA wishes to document this critical electricity pricing issue and suggest a process to address this matter.

The OFA has met with the Minister of Energy. We advised him we will continue to identify short- and long-term steps that are essential to make the market work for farm and rural customers. Initiatives are now underway with our commodity partners to develop courses of action on demand-side management, conservation and new generation. OFA will contribute these proposals with a view to improving the provision of hydro for all of Ontario.

OFA recognizes the new government's efforts in addressing the pressing energy needs of our province. Until there is a satisfactory electricity market, the OFA strongly recommends that farmers continue buying electricity that is reflective of the actual cost of power used by farmers of Ontario.

For farmers, market prices for power from May to November 2002 were unpredictable and high. Prices in the summer of 2002 caused many farmers in horticulture to re-examine what they could afford to grow in 2003. For greenhouse growers, the market caused time-of-use meters to be withdrawn. For livestock producers, high costs were incurred in keeping herds and flocks alive and healthy. The 4.3 cents per kilowatt price cap was more costly for these farmers than the old mix of peak and off-peak power with time-of-use metering.

With the coming of the market, thousands of farmers were reclassified from farm to commercial for hydro purposes, and made to use demand meters. As a result, they went from a pre-market frozen price of 9.4 cents per kilowatt, energy and delivery included, to floating market prices and demand charges that took the whole cost of power from the 12-cent to the 20-cent range, depending on peak demand in the month for the farmer.

The 4.3-cent price cap did not protect them from high demand charges. Nonetheless, the 4.3-cent rate allowed farmers to plan ahead and enter into sales contracts for

2003 and now 2004 with some sense of what their costs would be.

As the average price of power has been 4.978 cents per kilowatt, budgetary constraints suggest that the 4.3-cent price cap should be replaced. There are several options for considering how farmers should be treated under regulated pricing while markets are being reworked to remove their present failings.

There are fundamental reasons why farmers should be given careful consideration with respect to power pricing. The OFA argues that based on evidence, farmers pay more for service and use proportionately more off-peak power than other customers. So the power that farmers use actually costs less than average. With respect to service costs, OFA believes farmers pay an appropriate share of rural distribution costs in Ontario. As mentioned, this cost is above average, although rural rate assistance reduces service charges to an acceptable level for residential users. However, farmers pay 30%, or \$12.5 million, more than their share of costs for transmission. Farmers had effective transmission prior to development of high voltage service. The high voltage service, installed to serve urban and industrial growth, created a higher cost to farmers and rural residents who did not need it.

For the costs of power the following facts support OFA's views that farmers use lower-cost power.

Farm power use on weekends is almost as high as it is on weekdays, while power use for virtually all classes of customers is much higher on weekdays than on weekends. Accordingly, farm use draws more heavily from this low-cost period than other users.

Farm power use starts earlier and ends later in the day than in many other kinds of business. This broader distribution of use through each day reflects work patterns.

The ratio between the base level and the peak level of farm use is lower for farms than for other kinds of users. This indicates that farmers contribute less to peak demand than other users, and hence they are using less-costly power. Farmers do not have a summer seasonal peak use at all. In fact, farm use falls in the summer, whereas it is the major peak for almost all other Ontario users. Farmers have a winter usage peak, which is the only time when our usage coincides with the usage by others in Ontario.

In comparing farm power use by price group with all of Ontario for the period of the market, farmers used more low-cost power and less high-cost power than Ontario as a whole. These considerations strongly indicate that farmers do not contribute to expensive usage spikes, and the power they use costs less than average. Based on the 4.9-cent average power cost, OFA contends that a farm price in the range of 4.3 to 4.6 cents accurately reflects the cost of power used by farmers. In addition, as indicated, farmers are already paying at least the full cost of the distribution service plus an inordinately high portion of transmission costs.

Farm businesses in Ontario have faced very severe times over the past four years. OFA's farm members do not have the luxury of passing sudden increases in

electricity costs to their customers. Farmers typically take a price and, quite frankly, those prices are already insufficient across the spectrum of commodities we produce. Farmers need to pay the value of the electricity they use in order to honour existing contracts for fruits and vegetables with high storage or greenhouse growing costs. Ontario farmers pay hydro costs in excess of \$250 million annually. Each one tenth of a cent increase in the energy price costs farmers an extra \$3.5 million. In three of the past five years, farming in Ontario has had net incomes of about \$350 million. Therefore, each one tenth of a cent increase takes one per cent from that income. The proposed change in the regulated price will eliminate \$42 million from Ontario's net farm income, and that's coming right out of our pockets. How will it be replaced?

The OFA is not suggesting that farmers be treated preferentially. Rather, we recommend an amendment to Bill 4 that would provide a two-tiered price with a summer top-up that would apply to commercial and residential users. The first tier would be in the range of 4.5 cents and would be for off-peak users such as farmers, residential, electrical and electronic manufacturers. The second tier is a price just over 5.5 cents per kilowatt average and would apply to users on ordinary metres that use more costly power. The summer top-up would have an 8.5-cent price for commercial and residential power use over 10,000 kilowatts in the summer months. The government's lower cost to 750 kilowatts per month for all users should be retained, as it addressed conservation efforts and those on fixed incomes. This approach can be made financially viable by fixing OPG prices for power from its nuclear and large hydro units over 100 megawatts to OPG's cost plus an 8% return. There would be no further subsidy in this price and no further contribution to Ontario's debt. Users would pay the full price based on their use patterns, and OPG would still have a profit. Quebec and British Columbia use this approach now for their baseload power plants.

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In closing, the current electricity plan, as it is framed in Bill 4, is unfair to those in the business of farming. It reflects an increase to average consumers of around \$6 a month but over 10 times that amount for individual farmers. We have proven that farmers use cheaper power than the rest of our economy. Farmers are simply cross-subsidizing the average user on power costs and transmission costs and will do so to the tune of almost \$55 million out of net farm income.

Farmers and the OFA are asking that hydro be priced to reflect farmers' real costs. It is essential that the needed short-term rate adjustments do not unfairly penalize the agriculture sector at a time when it is most vulnerable. We ask that the amendment reflecting the two-tier approach, as we have set out in this document, be considered and passed on by this committee.

The Chair: Thank you, Ron. Starting with Mr Kormos, five minutes.

Mr Kormos: Thank you kindly, gentlemen, both of you. You know I'm from down Niagara way.

Mr Bonnett: Yes.

Mr Kormos: The cattle producers took a beating, of course, across the board this summer. We've got a lot of poultry producers. Those would be high electricity consumers, right? The poultry farms?

Mr Bonnett: Yes.

Mr Kormos: And then we've got a lot of the flower greenhouses; that's the big growth industry. That's got to be real high electricity consumers, huh?

Mr Bonnett: All of those—predominantly the greenhouse and the livestock barns would be high energy users, yes.

Mr Kormos: So this is bang on for the folks down where I come from.

Mr Bonnett: That's right. If you look at most modern farm operations, whether it be livestock operations or greenhouse operations, a lot of those have adopted, as we said, new technology, and that new technology utilizes energy. But the other thing you have to remember, as we presented in our brief, is that that power consumption is very stable and does not contribute necessarily to those high peaks.

Mr Kormos: You're not creating those peaks; if anything, it's to the contrary.

Mr Bonnett: We're not creating those peaks. It's baseline load. Actually, if you look at the summer use, our summer use is less than our winter use. If you were to flatline—some of the power we're saving in the summer is available to other consumers.

Mr Kormos: I trust that part of what you're saying is that the balance is so delicate for farmers—because that's what the guys and gals down where I come from tell me—that it's a matter of implementing the recommendations you make right now; not waiting.

Mr Bonnett: That's right. The other thing is that a lot of the farm businesses now are forward-contracting a lot of the product they sell; they factor in what their costs are going to be, and that's part of the long-range planning that takes place. So if power bills do go up, there's only one place it can come from, and that's out of the farmer's pocket. That's why it's so dramatic, like we said in our brief. If you take the averages, the average farmer is going to take 10 times more out of their take-home pay than the average consumer, and that's where it's going to really hit.

Mr Kormos: Was the OFA consulted in the course of preparing this legislation?

Mr Bonnett: We have actually been working with both governments over a long period of time. We've been quite involved. We were involved with the Conservative government before. We've been involved with the new government. These are not new concepts. We've been pushing and refining these concepts for some time.

Mr Kormos: The concept you're proposing in this submission today?

Mr Bonnett: Yes.

Mr Kormos: Yet it's not found in the legislation. What's going on?

Mr Cowan: We did meet with the minister approximately three weeks ago and presented a proposal very

similar to this. That was prepared on short notice. We've refined it a bit. It has an average price, a below-average price and an above-average price. It more than covers the total cost of power. People who use expensive power pay for expensive power. People who use less expensive power pay less.

Mr Bonnett: In fairness too, the minister has set up subsequent meetings, and we've been meeting with different people along the way. But one of the things we'd like to reinforce in this time frame between now and April 1—which is an interesting date—is that it's time to make sure we get it right. This committee could take a look at the recommendations, which lead toward a pricing formula that really contributes to consumers recognizing what the cost is and that they be rewarded if they use lower-cost power versus having a flat price. A flat price doesn't address some of the conservation issues and those other types of issues that need to be addressed.

Mr Kormos: Did your talks with the minister show promise? Do you expect the parliamentary assistant to produce the amendments that you're proposing?

Mr Bonnett: Part of the reason we're here today is to put these amendments forward to this committee, and we would expect that she would be carrying forward our views.

Mr Kormos: Thank you kindly. I'm looking forward to that as well.

The Chair: We go to the government side for questions.

Mr Gravelle: Thank you very much. I appreciate your being here. It is fascinating in terms of the use of off-peak and peak hours, which probably a lot of people wouldn't understand unless they had a pretty good understanding of how the farming world works.

I'm from northwestern Ontario, Thunder Bay, and we don't have a lot of farmers up there.

Mr Bonnett: You have quite a few. I'm from Sault Ste Marie.

Mr Gravelle: I'm from Thunder Bay-Superior North, and I must admit that in Thunder Bay-Atikokan, in the South Gillies area and going west to Fort Frances, there are more; in Thunder Bay-Superior North there aren't as many.

Having said that, I know a lot of farmers, and I know how much this means to them as well. But I was interested in and pleased with the fact that you have had meetings with the minister and with the ministry, and it does sound like you're somewhat encouraged about the process that you're part of now in terms of the discussions that are going to be going forward in the next couple of months. Is that an accurate reflection? Do you feel you're being listened to?

Mr Bonnett: Yes, actually. We've heard the words that we're being listened to, but I think we'd like to have it reflected in the pricing formula. As you're going through and putting the pricing formula in place for this new bill, I think it would be appropriate to take a look and see if that is the best solution, just establishing a new cap. Our position has been that that's not necessarily the best solution and it should be looked at before you go

down that road, because once you start down a road, then it's hard to retrack and try to get it right.

Mr Cowan: We've also been involved in the conservation and new generation task force that has just recently started its work, and we've also been very active on the Ontario Energy Board's demand-side management and demand-response panel. For roughly the past six weeks it's been going, we've been there all the time. We are putting forward to Hydro One, which is our main PUC, if you will, a range of proposals for conservation and line-loss management and so on which we think could reduce bills. So we're working on all sides of that. We do believe people are listening to us.

Mr Bonnett: I should mention that this presentation is very specific to the pricing side of the argument. We have a complete policy paper outlining some initiatives on the conservation side, initiatives on the generating side, we've identified some of the obstacles there, and that is available to any committee members who would like to have that. But it's a much more complex paper, and there wasn't time to go through the detail of that at this time.

Mr Gravelle: It would be interesting to have. You have some very strong advocates, of course, on the government side and you know many of them well. I appreciate your being here to put this forward.

May I also say—and the new members will get to learn this—I think the OFA is one of the best organizations in terms of keeping members informed of the issues. I receive material on a regular basis in terms of all the issues, and it's much appreciated. We're grateful to have you here today.

Mr Bonnett: Thank you.

The Chair: Jim, you have about three minutes left.

Mr Brownell: It's probably more of a comment than a question. As a former educator, and I mentioned that this morning, in working with students you always work with conservation, and that information is taken home. You just mentioned here that you had been working on conservation. I'm very pleased to hear that you're willing to share that information with us. I think it's important that we get it. I'm always interested in finding out as much as I can what the other side or the general public is doing with regard to conservation and what concepts they have.

Governments can do all they want with regards to pricing and whatnot, but if conservation isn't a big part of it, it's not going to work. You having said that, I really appreciate and look forward to receiving any information from you regarding that.

Mr Bonnett: On a lot of the conservation stuff, we're looking at replacing different types of motors, a different way of managing our farms. Some of the conservation is trying to shift peak loading periods even more, using switching equipment to have some of the heavy drawing equipment use power at off-peak times. There are all kinds of measures that can be taken on that.

1720

On the generating side, we just had some discussions with the conservation side of OPG on the use of wind-

mills. There are a number of land use policies that need to be addressed around that. There are also some issues around what the connection costs are.

One of the other things that came out as part of the discussions that took place last summer, when we were getting really close to a balance in generation capacity after the blackout, was the fact that there's a lot of generating capacity on-farm that, if necessary, could be brought on line to service those farms, if there was some kind of mechanism for rewarding those farmers who generated that power. Our figures show that the farmer can generate that power for about 20 cents on-farm. If you're buying power from the grid during peak periods at \$1, it would maybe make sense to have that farmer go off grid and produce their own power for a short period of time. There are all kinds of innovative things like that that can be done to address some of short-term needs from the generating side. On the long-term side, I think it's a lot of conservation efforts and making sure those conservation efforts are rewarded with a pricing system that recognizes those efforts. That's where we have to go as we work our way through this.

Mr Jackson: One question, and then I'll yield to my colleague the agriculture and rural affairs advocate, Mr Hardeman.

Gentlemen, thank you for a very comprehensive brief. In your pricing, were you aware that it's not only the price that will be going up to the new cap but also about \$1 billion of additional charges that will be allowed for the LDCs, the local distribution companies? We also found out earlier today that once the meter begins for the payback for OEB-approved increases, they can apply again within any period of time and not just after the four-year cycle. Have you costed that into your projections?

Mr Cowan: No. The \$55 million you look at there is the energy cost for \$42 million; what we believe is a 30% premium we pay on transmission, approximately half a cent a kilowatt hour. But as to the point you've indicated, approximately \$129 million in unrecovered profit has been put into a suspension account by the energy board for Hydro One. The rural and farm share of that we think will be in the vicinity of \$18 million or so, I gather, spread over four years, potentially. In addition, there are some other costs which have not yet been approved which will likely be allowed to be recovered. Again, that charge will come through. The numbers we gave we believe are firm and cautious. We'd have to add in some of the—

Mr Jackson: But only on the half which is the energy cost as opposed to the upcharges and all the other half of the bill.

Mr Cowan: You're quite right. In addition to the \$55 million, there is somewhere between another \$5 million and \$15 million for farmers, but because it's between \$5 million and \$15 million, I didn't really want to say whatever that number averages out to—I guess \$10 million.

Mr Bonnett: Just for clarity, you brought up a bit of an issue about the high-voltage transmission. I don't

know if there's a really good awareness in the general public, but if you take a look at power consumption in the GTA and the Horseshoe area, that's where a lot of the high-voltage power has to travel. It's basically a high-speed pipe, taking it from the generating facilities, whether it be Bruce Nuclear or whatever, to bring that power down to service those centres. The cost of that high-voltage transmission is not just spread around the GTA customers who are using that power; that high-voltage transmission cost is spread out to all rural users. They actually do not get a benefit from that, because their power predominantly is generated locally anyway. So they don't draw from that grid; that grid is feeding directly into the centres. That's one of the reasons we say there is an unfair charge put on rural residents for that high-voltage transmission cost.

Mr Cowan: If I could add just a little to the arithmetic of that, there is 1.55 cents per kilowatt hour for transmission on every kilowatt hour used in the province, but the power from, say, the Ferndale windmill, up on the Bruce Peninsula, never goes near a transmission line. It's all used before it gets near a transmission line. Transmission shouldn't be charged. There's 1.5 cents being taken there that is discouraging windmills all over the province.

Mr Ernie Hardeman (Oxford): Thank you very much for your presentation. I just want to go to the principle of how we got here with this bill. I'm sure we have a lot of good federation members too in Oxford that I talk to quite regularly. To them it was quite a surprise that this bill came out in the first place. I hear there was some consultation with you, but I guess this consultation didn't get to the people who live in Oxford, because my farmers were quite concerned. They had been assured that they would not have a price increase until 2006, and all of a sudden, as you mentioned, they don't have the ability to incorporate extra cost in their cost of production as they sell their product. So they can't get it back. All of a sudden they find themselves in this dilemma where their costs are going to go up and there's nothing they can do about it, when they were assured it wasn't going to happen.

Did I hear you right that you were consulted prior to this bill coming out that we were not going to stick with the cap, as had been promised by the government; that they were going to have a new bill that was going to change the cost for you?

Mr Bonnett: We were consulted right after the election. Basically, they were looking at the whole issue of hydro costs and how they were going to deal with it. At that meeting, we made the same type of presentation we had made on a number of occasions. We were never supportive in the long term of a price cap. At the time it came out, we fought very hard to have fairness. If somebody else was going to be paying for 4.3, we wanted to be paying 4.3. But even if you go back to our

position papers before that, we were always talking about getting a pricing system in place that would reward those people who did things like shifting power to off-load periods or using low-cost power, and other people who use high-cost peaks would pay.

Mr Hardeman: The farmers who live in Oxford who have been talking to me, did they know that the federation's position was not to maintain the price cap?

Mr Bonnett: They knew that our position was to have a pricing formula that would have them pay the fair price for power, which in our calculations was around 4.3, 4.4, 4.5. They were aware of that, but they were not aware that there was going to be a sudden lifting of caps. I don't think anyone was aware of that.

Mr Hardeman: That's really what I was trying to get to.

Mr Bonnett: There are two separate issues here. One is the fact that the cap is to be lifted with this bill. I don't think anyone had anticipated that. But the other issue of OFA policy and position has been, for several years now, that we have to have a pricing mechanism that works; not only the pricing mechanism on the farm side or on the consumer side, but there also has to be a pricing mechanism on the market supply side as well. Some of that information is contained in our paper. If you set up a market system where generating companies are bidding, it has to be set up so that it's a fair type of market.

Right now what happens is the highest bid is the established price for power to be sold. I'm a livestock farmer. That would be actually a great situation for me if I could ship my cattle and, whatever the highest price for the cattle base was that day, everybody would get that price. But that system is not sustainable. If you want the market to work, you have to set up the market properly. Just the same, if you want the pricing—

Mr Hardeman: I'm not debating whether the present system was sustainable. The people I represent talked to me at great length that they were promised and guaranteed that this price would be there at 4.3 cents until 2006.

Mr Bonnett: And I think that's the premise for our presentation. The calculation has been made on the costing that it was going to be at 4.3—

The Chair: This will have to be the final answer.

Mr Cowan: We understood that the 4.3 was through till 2006. The new legislation changed that. We've had to face this reality and we've put together what we think is a rock-solid approach to pricing power for everybody in Ontario in the short term.

The Chair: Very good. Thank you very much.

Before we adjourn, just a reminder for members that the deadline for amendments to the bill is 7 o'clock this evening, with the clerk of the committee.

OK, we're adjourned. Thank you for your co-operation.

The committee adjourned at 1730.

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Wednesday 10 December 2003

Journal des débats (Hansard)

Mercredi 10 décembre 2003

Standing committee on
justice and social policy

Comité permanent de la
justice et des affaires sociales

Ontario Energy Board
Amendment Act (Electricity
Pricing), 2003

Loi de 2003 modifiant la Loi
sur la Commission de l'énergie
de l'Ontario (établissement
du coût de l'électricité)

Chair: Kevin Daniel Flynn
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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON
JUSTICE AND SOCIAL POLICY

Wednesday 10 December 2003

*The committee met at 1000 in committee room 1.*ONTARIO ENERGY BOARD
AMENDMENT ACT (ELECTRICITY
PRICING), 2003LOI DE 2003 MODIFIANT LA LOI
SUR LA COMMISSION DE L'ÉNERGIE
DE L'ONTARIO (ÉTABLISSEMENT
DU COÛT DE L'ÉLECTRICITÉ)

Consideration of Bill 4, An Act to amend the Ontario Energy Board Act, 1998 with respect to electricity pricing / Projet de loi 4, Loi modifiant la Loi de 1998 sur la Commission de l'énergie de l'Ontario à l'égard de l'établissement du coût de l'électricité.

The Chair (Mr Kevin Daniel Flynn): If you can take your seats, I'll call to order. We have a quorum I think.

Interjection.

The Chair: I'd just like to have one.

Mr Peter Kormos (Niagara Centre): Point of order, Chair: It's entirely irrelevant as to whether or not there's a quorum.

The Chair: I realize that.

Mr Kormos: The Chair has called the meeting to order. It's for the Chair to call the meeting to order, with all due respect, at the time indicated and then it's for the committee to deal with whether or not there is a quorum, with respect.

The Chair: Thank you. In this case we do have a quorum and I have called the meeting to order.

We are here to consider Bill 4, An Act to amend the Ontario Energy Board Act, 1998 with respect to electricity pricing. We're going to start with a five-minute statement from each of the parties, as agreed.

Mr Klees, I was going to go to the official opposition first. Would you prefer to wait for—

Mr Frank Klees (Oak Ridges): I think that would be appropriate.

The Chair: You would like to go first?

Mr Klees: No.

The Chair: OK. Mr Kormos, you will wait?

Mr Kormos: Yes, it's the government's bill. Let them pitch it.

The Chair: Who will be speaking on behalf of the government first? Five minutes, Donna.

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

COMITÉ PERMANENT DE LA JUSTICE
ET DES AFFAIRES SOCIALES

Mercredi 10 décembre 2003

Mrs Donna H. Cansfield (Etobicoke Centre): Thank you very much, Mr Chair. I was anticipating that my colleagues would go first, though.

Mr Kormos: Why?

Mrs Cansfield: Why not?

I'd like to make some comments about the bill, in essence to deal with the overall issue and the overall message, which is that the existing price of 4.3 is not sustainable in the long term and that in fact the cost of the rising debt and, in addition to that, the anticipated cost of sustaining that price, is not something that this government can hold as a concessionable way of doing business. In essence, the first part of the strategy on electricity addresses that issue.

I'd like to indicate to all present that this is just the beginning of a very long-term strategy involving the electricity market as well as dealing with conservation issues and the concepts around environmental, societal and economic benefits and sustainability.

There are a variety of methods and issues that we'll be looking at, and certainly within agriculture they have identified the different kinds of ways and means by which they wish to conserve, and I think they have also identified the fact that the 4.3 was not acceptable to them as well, that there were alternatives they were prepared to sit down and speak to, in particular to differential pricing on peak and off-peak periods.

The issue around education is critical and it's something that is going to change, not only in terms of culture but in behaviour. That is something that is not going to happen in the short term. That is something that is going to happen in the long term, and there will be a very comprehensive approach to that. It is not dealt with in this bill. It will be dealt with in the future. All this bill does is identify that in fact education is a critical component, so that we're looking at the short term, medium and long terms.

We're also looking at the issue of investments for the long term. As the minister had indicated yesterday, there is a place for both public and private in terms of the strategy. I believe also that he had indicated previously many times that in fact the issue of coal will be off the table by 2007. So obviously the three words he uses constantly are "supply," "supply" and "supply."

There is no question—everybody has been very straight up—that this is going to be a cost that has to be borne by all sectors if we're going to deal with the real price of electricity. If you look at those who have come

forward in support of lifting this cap, you'll see that there is a litany of people and associations, from not-for-profit business to large corporations and small businesses as well, that say we need a far more comprehensive energy strategy in this province than we currently have and that we need to look to a long-term sustainable goal for energy as well in this province. So we need to find a way to build our capacity, we need to find a way to have sustainability, and we need to look at how we can work together to make a difference in terms of ultimately what the decisions will be for energy in this province.

As I indicated before, this bill addresses initially the cost of energy and returning it by the year 2005 to the Ontario Energy Board, which will be the regulator in a nonpoliticized way in dealing with the regulated market price of energy so that people can have a stable, sustainable market price, as opposed to the volatility that they've had in the past.

Certainly all of the people I have spoken with—and we've had a significant amount of input from the industry itself, from the local distribution companies, from consumers, from advocates, from conservationists—have, without a doubt, indicated the need to look at conservation as an important component of the energy strategy in this province.

I know also that a number of the issues that have been brought forward by recommendation will be dealt with in regulation, if they have not already been dealt with in regulation, and that will be coming forward in the new year.

So again, we're pleased to have this bill in committee and we believe that it addresses the new and emergent needs of electricity pricing in this province.

The Chair: Thank you, Donna. Is the official opposition prepared to proceed with its five minutes?

Mr Cameron Jackson (Burlington): Thank you, Mr Chairman. I think it needs to be put on the record, the express concern of many Ontarians that the genesis of this bill emanates from a broken promise made by the incoming government. This is a serious broken promise. As I have indicated on the floor of the Legislature, this was a deliberate decision on the part of the government. It was deliberate and it was wilful and it was deceptive to suggest throughout an election, as was the performance of the Liberal members in government, that they support a cap, that they support consumer protection, to convince Ontario voters that this was exactly what they would do once they became government. It has been confirmed from a variety of sources that this government's intention was to not fulfil that election promise; in fact, quite the opposite.

It is not good public policy, no matter how you sugar-coat it, when you blindside the voters of this province. Perhaps their growing cynicism with the approach this government takes is reflected in the lack of interest being shown by the public in participating in public hearings and in making any written submissions to the government or to this committee.

Any comments that we might make that contribute to furthering the bill would be pointless, because we don't

support this bill. We believe the cap should remain in place for the prescribed period of time, until such time as we have put in place those elements that, in fairness, the government speaks to but doesn't include in the bill. Those deal with consumer protection, ensuring greater supply, to equip consumers with the instruments that empower them to be effective consumers and conservers of energy. This is not going to occur within the time frame set out in this legislation; therefore, it is bad legislation.

1010

We have several amendments that we are prepared to present, based on public input. We will speak to those if called upon, but frankly, this is poor policy built on a broken promise to the voters of Ontario.

Mr Klees: Is there any time left?

The Chair: About two minutes left, if you'd like to speak, Mr Klees. Go right ahead.

Mr Klees: To follow up on my colleague's comments, just to reiterate, I suppose the one thing that we don't disagree with is that there has to be an exit strategy from the cap that was put in place by our government.

We have to remember the reason for that cap. No one wanted to put a cap in place. There were some extenuating circumstances. It has been referred to as the perfect storm of energy, with incredibly high temperatures, with generation capacity at probably its lowest point in the history of the province. The convergence of those events resulted in skyrocketing prices at a time when the market had been opened. We, as a government, came forward with a strategy that was very, very specific, and that was to protect the vulnerable people within our province: the seniors, people on fixed income, and small and medium-sized businesses, who could not cope with the spikes that resulted from the convergence of those events.

We said from the very beginning that there has to be an exit strategy. We put the exit strategy out to 2006. We said that we would be able to lift that cap, and would, when there was sufficient generation capacity within the marketplace to bring balance to the marketplace. My concern with this legislation is that it not only pre-empts the promise that was made by the Liberal Party during the election campaign, but I believe it also pre-empts the reality of the circumstances we face in this province. We don't have the generating capacity yet. I don't believe that it will be in place in sufficient time to deal with the potential problems that will be caused.

We heard from presenters to this committee who expressed concern regarding those same groups—seniors, people on fixed incomes, small and medium-sized businesses, and the farming community. There will be problems. These people will be facing fiscal challenges. I believe that this government is being irresponsible in moving forward with this legislation.

I do hope that at least the amendments that we're putting forward will be accepted by this committee, will be an opportunity for this committee to demonstrate clearly that this government is open to having input from the public, from the opposition, to ensure that legislation

that is passed in this place—while we don't agree with this in principle—at least is made better than it is and protect vulnerable people. I will be observing the proceedings here to see what happens with these amendments, to see whether this government is serious about doing government in a more democratic and open way.

The Chair: Mr Kormos, five minutes.

Mr Kormos: Thank you kindly. I say to Mr Klees, you won't be observing them long because it's not going to take long for this to be wrapped up. In fact, we have but this morning for clause-by-clause consideration, and that includes consideration of the Conservative amendments, and that's after a pathetic three hours and 35 minutes or so of public hearings. That's pretty darn near unprecedented. So once again the Liberals have a first here at Queen's Park. Mr Gravelle can correct me if I'm wrong. He has been here a little longer than his colleagues on the committee. If I'm wrong, Mr Gravelle will be sure to point out when there has been a bill that has received less public hearing when in fact public hearings have been committed. Do you understand what I'm saying, Mr Gravelle? When the government of the day has committed itself to public hearings, as yours did, I'm not aware of public hearings being any shorter. There have been times when the government has said, "There will be no public hearings." I understand that. I can't recall a single occasion in which the government committed itself to public hearings, as yours did, and there was less time. For the life of me, I just don't understand.

That's hyperbole on my part; it's rhetoric. I do understand it, and I think I understand it full well.

The problem, you see, is that this is what happens when you time-allocate bills. This bill was rushed into committee because that's what the time allocation motion said, right? It had to go to committee immediately. That meant that there were no effective public notices around the public's right to participate, which is just as well, because there was only, as I say, three and a half hours, give or take, for the public to participate. So it would all be pretty inherently contradictory. If you had had proper advertising, you would have had far more people than would occupy but three and a half hours, give or take.

The other remarkable thing, of course, is that you've got a 7 o'clock deadline for filing amendments. The Tories, to their credit, although they don't appear to be particularly responsive to any given submission—and that's fair enough. There's nothing wrong with that, because really it's the government's job to respond to the submissions at the end of the day—isn't it, Mr Hardeman? Of course it is. It's the government's job. You know that. You were in government for the last eight and a half years, give or take. It's the government's job.

How, for the life of me, can this government and its committee members—I do want to pay tribute to Ms Anne Marzalik, the research officer who has been assigned to this committee hearing. You realize what you made her do? She had to work last night, prior to the committee resuming this morning, to prepare her

synopsis of submissions. Amongst other things, the style around this committee hearing is grossly unfair to these hard-working staff. I suppose Ms Marzalik's saving grace was that there were so few submissions because, of course, you only had three and a half hours allotted, give or take, for public hearings.

Mr Klees: Six, Pete.

Mr Kormos: When? Ten to 12—

Mr Klees: Six people.

Mr Kormos: Yes, six people. As I say: three hours, three and a half hours, give or take. We had to listen to Mr Duncan with his prepared statement—which was, I suspect, thoroughly anticipated by all opposition members. I am so pleased about the shots he took at the NDP in the course of his submissions, because it signals to me, as a New Democrat, and to the public that there's some concern by this government about the NDP, which of course is reinforced by this government's heel-dragging on giving the New Democrats meaningful participation. We're going to get it one way or another, if we have to burn the House down, so to speak, in a most proverbial way.

I hope you guys are proud. For some of you, it's your first time sitting on a legislative committee, and I congratulate you. But at the same time, you should be oh-so-proud on your first occasion sitting on a legislative committee, because over the course of the next several weeks, people are going to be saying, "What?" When you go back home, they're going to say, "There were committee hearings? I never knew about them." You're going to say, "Well, they were advertised on the legislative broadcast channel for several hours throughout the course of the night."

If you're one of those people like me who's up at 3 in the morning and you're clicking through the clicker and you run out of infomercials and pass by the legislative channel, you pause for the briefest of moments at 3 in the morning, sitting there in whatever you happen to be wearing at 3 in the morning—I don't want to discourage any of you by detailing my scenario, but there it is. At 3 in the morning, I can't sleep, I've got the clicker, and I find, my goodness, there's a committee hearing tomorrow morning at 10 o'clock. That's big. That's really big of you guys. That's really inclusive. That's really democratic to let people know at 3 in the morning that they can make a submission at 10 that same morning. By God, that's openness. That's democratic and reformist by anybody's calculation of it, ain't it, Mr Gravelle?

When you get back home, you're going to be confronted with folks who are going to say, "What committee hearings? How come nobody told me? You're my MPP. You should have told me there were committee hearings. That's why we elected a government member. You guys were campaigning on the basis of, 'Elect a government member so you've got the inside track.'" The people are going to say, "We elected the government member; where's our inside track? How come I never knew about these committee hearings? You're lifting the cap; you promised you wouldn't."

Not that that promise was the right thing to promise, but you promised you wouldn't. You travelled the province—

The Chair: Are you wrapping up?

Mr Kormos: Yes, I'm wrapping up. Of course I am. I know it's five minutes.

You travelled the province, you travelled your ridings, and promised to keep the cap at 4.3. You break the promise and you deny the public access to committee hearings.

The Chair: Thank you, Mr Kormos.

Mr Kormos: I'm knocking the house down here.

1020

The Chair: OK, are there any comments, questions or amendments and, if so, to which sections or schedules? I note that there are no amendments to sections 1 through 4. Would you like to collapse those and vote?

Mr Kormos: No, no, no. We're discussing it clause by clause.

The Chair: OK, I was giving you the option. Obviously you don't want to, so let's go to section 1.

Any comments or questions to section 1?

Mr Kormos: Perhaps the parliamentary assistant could explain to us—because this section appears to replace a repealed section—what the impact of this amendment is.

Mrs Cansfield: It's the legal precedent for the rest, I presume. I'll ask legal counsel to explain it to you.

Mr Kormos: Sure. Then maybe you could cover the politics of it for us.

Mrs Cansfield: I'd be happy to.

Mr Kormos: Why don't we cover the politics first and then we'll deal with the legality later.

Mrs Cansfield: No, you actually asked a legal question first. We'll do it first.

The Chair: The question has been asked. You're going to get an answer.

Mr Kormos: Maybe. Don't be presumptuous.

The Chair: You're going to get an answer. You may not like it.

Mr Stephen McCann: My name is Steve McCann. I'm in the legal services branch of the Ministry of Energy, and with me is my colleague, James Rehob, who is also in the legal services branch.

If I understand the question, we're dealing with section 1 of Bill 4, and the question was, what does it do or what is the purpose? What it does is amend section 78 of the Ontario Energy Board Act, which deals with the authority of the Ontario Energy Board to fix rates for the distribution of electricity. It in effect creates further modifications or conditions to the manner in which the board fixes rates, by adding a new subsection (5) to section 78, which would require the board to approve or fix separate rates for situations that are defined in the regulations, and in a new (5.0.1) would indicate that "In approving or fixing just and reasonable rates for the retailing of electricity in order to meet a distributor's obligations under section 29 of the Electricity Act," the board is to comply with the regulations made under regulation-making power.

I should just point out that section 29 of the Electricity Act is essentially the section that obliges distributors to provide electricity to their customers in their service area when there is no retail contract in place with an electricity retailer.

The reference then is to regulation-making powers which are contained later in the bill. I guess we'll get to those, but just for reference, they're in section 11—(g.4) and (g.5) would be the regulation-making powers.

Mr Kormos: Having said all that, there already was a subsection (5) of section 78, which was repealed by the last government. Does the subsection (5) which is now amending section 78 by replacing the repealed subsection (5) replace the subsection (5) that was repealed, or is it a variation on the subsection (5) that was repealed?

Mr McCann: My recollection—I don't have the repealed section handy here. I believe it deals with a different subject matter, but we could check on that, I think relatively promptly.

Mr Kormos: I think that's important, don't you, parliamentary assistant?

Mrs Cansfield: It's a question you've asked. It needs to be answered. We'll get the answer for you.

Mr Kormos: If you could assist, I'd be pleased to hear from you.

Mrs Cansfield: I believe that the legal branch of the ministry is doing an admirable job.

Mr Kormos: Chair, then, can I ask the parliamentary assistant what the policy motive was behind restoring subsection (5)—not the legal issue, the policy issue.

The Chair: You can certainly ask. Mrs Cansfield?

Mrs Cansfield: I'm sorry, you'll have to clarify that for me. I don't understand your question.

Mr Kormos: I'm asking for the policy motive behind this amendment.

Mrs Cansfield: With the LDCs providing electricity?

Mr Kormos: No, the policy motive behind section 1 of your bill, which is the amendment to section 78 of the act with subsection (5).

Mr Brad Duguid (Scarborough Centre): Refer it to staff.

Mrs Cansfield: Yes, I think I will. If I could ask staff—

The Chair: The question has been asked. Mrs Cansfield has referred it to staff.

Interjection.

The Chair: You can ask the question, Mr Kormos. Who answers it I think is up to the respondent.

Mr Kormos: I'm just protecting the independence of the civil service.

Mrs Cansfield: If in fact there was a question like this, you should have asked the minister when he was here the other day. Having said that, we now have somebody here who can answer that question for you.

Ms Rosalyn Lawrence: My name is Rosalyn Lawrence. I'm the director of the consumer and regulatory affairs branch with the Ministry of Energy.

Those regulation-making authorities are designed to allow for regulations that would support a two-block

pricing structure as well as the ability to set rates around time of use of electricity.

Mr Kormos: If I may ask the parliamentary assistant, I understand what the role is from a policy perspective. How is this policy perspective consistent with the campaign commitment made by the Liberals, yourself included, in the campaign on which you were elected?

Mrs Cansfield: Very consistent, Mr Kormos, because I campaigned on responsible government. Certainly, responsible government means dealing with the issues at hand, and a \$5.6-billion problem is an issue at hand.

Dealing with this in particular, it's a response to all of the people we met within the electrical sector as well as consumers who were looking at options to be provided. This certainly is a policy that provides a variety of options. It looks to interval metering; it looks to time of use; it looks to alternatives that can be put in place. So it's well within the policy of this government in terms of responsible government.

Remember that the whole idea of the cap was that it was to be debt-free and revenue-neutral. It is neither. It increased the debt and it cost us money.

Mr Kormos: Ma'am, we knew that the cap had cost at least \$600 million, if not more, at the time of the election call. That was public information that was acknowledged by indeed even the Conservatives, that there was a price tag attached to the cap. You say it's consistent. I'm asking you, in view of the fact that we all knew the cap had a cost inherent in it, that it was acknowledged even by the government—this wasn't anything around which there was any obfuscation—is it then consistent with your promise to maintain the cap, this amendment today?

Mrs Cansfield: It's consistent with our promise of responsible government. Remember, this is one part of a very large issue around electricity. The other, of course, is the Epp report, OPG. I mean, the issues go on and on. It's quite consistent with the policy of the Liberal government for responsible government.

Mr Kormos: Was it responsible for you and other Liberals to campaign on the promise to maintain the cap?

Mrs Cansfield: Mr Kormos, if you want this debate in the House, it probably would be a better place to have it, instead of trying to debate the debate all the time.

Mr Kormos: No, you moved time allocation. We can't debate this in the House.

Mrs Cansfield: My colleagues across the way agreed to that particular way of doing business. If you had these questions to ask, you should have asked them before, when you had the opportunity.

Mr Kormos: Chair, point of order—

Mrs Cansfield: I have answered his questions.

Mr Kormos: Chair, we're here to put questions—

The Chair: There's no point of order. You can make comments, you can make amendments, and if you have questions—

Mrs Cansfield: I have answered your questions.

Mr Kormos: That's what clause-by-clause consideration is.

The Chair: That's exactly what we're doing.

Mrs Cansfield: The challenge is, Mr Kormos, you don't like the answer.

Interjection.

The Chair: No, no, and I'm certainly not chastising you from the chair for asking them.

Mr Kormos: Of course not.

The Chair: Keep asking. You may not like the answers, and we'll move on, but keep asking.

Mr Kormos: No, we won't move on until we're finished asking the questions. That's the problem with time allocation.

The Chair: We'll move on as the Chair dictates we'll move on. It's my job to make progress on this issue.

1030

Mr Kormos: Oh, really, Chair? On a time-allocated motion? No. You are the servant of this committee, Chair.

The Chair: We will proceed. You have the floor.

Mr Kormos: Of course I do.

Ms Cansfield, the thing is, you're here today to answer the questions. This is what the committee process is all about. This is what clause-by-clause consideration is. I'm asking you now whether it was responsible for you to promise your constituents that you would maintain the cap during the course of the election or during the period of the election campaign.

Mrs Cansfield: Mr Kormos, I guess you don't hear me. I have answered your question. I promised my constituents responsible government when I knocked on the door, and this is responsible to the issue at hand: an \$800-million problem. I think the comment was, "It's in a mess." It is in a mess. We need to deal with it, and we are dealing with it. So I've answered your question, not once, not twice, but three times now.

Mr Kormos: Let's try four. Did you not tell your voters that you would support the maintenance of the cap?

Mrs Cansfield: The Liberal platform was that they would support the price of the cap in addition to the fact that there would be responsible government. You're suggesting that irresponsible policy should continue, because it's irresponsible policy. I'm suggesting to you that the better policy is responsible government, and you just don't like the answer, sir.

Mr Kormos: I'm suggesting to you that Liberals voted for the cap. When they voted for the cap, they knew it was going to cost money, and irresponsible election promises are worthy of consideration and remark as well. Wouldn't you agree with that?

Mrs Cansfield: Of all people, I would think you would, because I recall the social contract with a great deal of—

Mr Kormos: Don't talk to me, Ms Cansfield, about that one. I'm on the side of the angels.

Mrs Cansfield: Right; I don't think so. When you talk about—

Mr Kormos: Let's see you break with your government on this one.

Mrs Cansfield: Excuse me, but it was your government's policy around the social contract. Having said

that, I don't think your particular party can throw slings and arrows at this. The fact of the matter is, it's responsible government to deal with an issue at hand. We are dealing with it, and that's the end of the question. It's been answered.

Mr Kormos: What I take from this, then, is that you're equating your breach of the promise to keep the cap to the NDP breach of its commitment to labour unions not to break contracts.

Mrs Cansfield: Those are your comments. What I was suggesting was that probably you would know better than most people around the issue of keeping bad policy. Having said that, I'm saying to you again, and for the last time, that this government is dealing with an issue at hand that's in a mess, and it is doing it as responsible government. You don't like the answer, and that's unfortunate.

Mr Kormos: Chair, if I may, the parliamentary assistant is earning \$15,000 a year above the base salary? Help me. I haven't bothered looking at the pay schedule. It would be academic. You're up into the \$100,000 club. To the parliamentary assistant: Can I ask her what amendments are being proposed by the government to this bill today?

Mrs Cansfield: There are no amendments being proposed to this bill by the government.

Mr Kormos: Can I ask the parliamentary assistant what was the net effect of the modest number of participants who attended the public hearings yesterday on the government's position?

Mrs Cansfield: The net effect?

Mr Kormos: Yes.

Mrs Cansfield: Would you define "net effect"?

Mr Kormos: What was the result? Did the participants not provoke any consideration of any amendments to the bill?

Mrs Cansfield: There were very positive results actually. I met with the Ontario Federation of Agriculture afterwards, and we have set up a meeting in January to discuss a number of the issues they identified in their paper, which will be their third meeting with us; also, we will be meeting in January with Chris Winter, who is very interested in working on the conservation end. So it was very positive. Having met with Ms Andrew, I think three times as well, it's been a very productive opportunity.

Mr Kormos: I'm glad the committee facilitated your booking schedules. I want to know, though, if any of the submissions made by any of the participants resulted in any contemplation of amendments to the bill.

Mrs Cansfield: I discussed the issues with the minister after the meeting, and I'm telling you now there are no amendments coming forward from the government on this bill.

Mr Kormos: You discussed them with the minister?

Mrs Cansfield: I did.

Mr Kormos: And the minister said what?

Mrs Cansfield: There are no amendments coming forward on this bill.

Mr Kormos: Did the minister say, "Those people can go pound salt," or did he say, "We'll deal with their issues later," or did he say there wasn't enough time to address their issues? What was the drift of it?

Mrs Cansfield: I just finished telling you that we have in fact agreed to meet with a number of the participants yet again in the new year to discuss some of their options and ideas. The minister knows what occurred at this meeting yesterday, and I'm telling you again there are no government amendments coming forward on this bill.

Mr Kormos: I understand. One final question on this motion: Is the language just the beginning of a long-term strategy, code language for, "We have no idea what the policy is going to be"?

Mrs Cansfield: Those are your words, not mine.

Mr Kormos: No, those are yours. I wrote them down while you said them: "just the beginning of a long-term strategy."

Mrs Cansfield: Absolutely. Of course it is. I think if you listened to what the minister said in the House, this is the first, it is the beginning of a long-term comprehensive strategy to deal with the challenges of electricity in this province. Of course, I would suspect, and you've been in government a lot longer than I have, that you know that supply in particular takes 10, maybe 15 years in some cases to deal with. Given the fact that there has been no supply dealt with in the last eight years, then certainly I would suspect you would like to have a long-term comprehensive strategy rather than a quick-fix band-aid solution.

Mr Kormos: Thank you, Chair.

The Chair: Thank you, Mr Kormos. Are there any further questions, comments or amendments on section 1?

Mr Klees: I just want to follow up very briefly on the issue of the rate cap and the understanding that the parliamentary assistant has of that cap, which the Liberal Party voted for, as Mr Kormos indicated previously. The reason I think it's important that we get clarification for this is that since the election of this government, I have consistently heard reference to the fact that this cap has a cost to it. As Mr Kormos mentioned earlier, it was always anticipated that there was going to be a cost to this cap in the early days while we were still dealing with a shortage of generating capacity, which is the reason the original policy of the cap had a time frame up to 2006.

When the previous Liberal Party, then the official opposition, voted in favour of that policy, it was clear to all in the Legislature at the time that there would be in fact a debt accruing under this rate cap policy. It was also discussed at the time, and with the assistance of the Ministry of Energy staff, industry consultants and the industry at large and its various stakeholders, it was also agreed that, given the addition of generating capacity that would come on stream as a result of the energy policy that would be put in place as contemplated by the government of the day, the cost for generating would decline as a result of competition in the marketplace, that the wholesale and retail prices would in fact be modified

and that over the period of time, it would be a revenue-neutral result.

There was no secret during the time the Liberal Party was campaigning and while the parliamentary assistant was knocking on those doors, there was no doubt in anyone's mind that there was in fact a cost attributed to this rate cap. Here we are today, and I was listening very carefully to the parliamentary assistant when she gave this explanation, as I've listened, by the way, to the Minister of Energy and others when they gave the explanation for an about-face on this commitment to keep this cap, this broken promise. Why was this promise broken to all those vulnerable stakeholders, who still, I suggest are very much exposed to fluctuating prices?

1040

The reason that I heard was, "We opened up the books and we somehow found out that there is this cost"—\$600 million or \$800 million, depending on the time of the day someone is speaking to it—"so in the interest of responsible government, we simply cannot keep our promise to keep this rate cap in place."

I say to the parliamentary assistant that her party knew this cost was there when they voted for this rate cap. They certainly knew when they were campaigning that there was a cost. What happened in the space of 48 hours that now we break that promise because this reality of the \$600 million, or whatever amount you may want to use, is the immediate cost? My question to the parliamentary assistant therefore is, if in fact the \$600 million was known and certainly is not a reason for lifting the cap, why did the government decide to break that promise? Because you can't argue the \$600 million. That was knowledge going in. Why?

Mrs Cansfield: I believe, sir, that it was \$800 million.

I'm going to quote something to you. It's a conclusion. "Ultimately, a lack of political will to pass higher and economically justified electricity prices on to consumers and restructure the generation market to attract private investment is responsible for the current disarray of the province's electricity sector." That's the C.D. Howe Institute's analysis of the very bad policy.

Mr Klees: What was the date of that?

Mrs Cansfield: That is December 2003. It very clearly articulates the challenges and the problems that we faced as we became government. It is irresponsible to continue on in that vein.

I reiterate: in order to deal with the issue at hand—because you are right; the initial analysis was that it would be revenue-neutral and it would pay down the debt. The fact of the matter is that it didn't work. So to continue something that isn't working, to have others subsidize the electricity costs, is not responsible. Its does not encourage conservation and it does not look at the realistic issues facing electricity. The \$800 million was one part of the puzzle. There are many parts to it.

I really do suggest you read it, because I know the Tory government uses the C.D. Howe Institute, or has in the past, considerably. They have done a very strong

critique of the previous government's policies dealing with the electricity sector.

Mr Klees: Does the parliamentary assistant acknowledge that the rate cap was never intended to be revenue-neutral after one year?

Mrs Cansfield: You may not have been in the House when I gave my remarks originally. I agree that in 2006 there was the intent of the Tory government to lift it. The NDP at one point didn't even want caps, then they did, and then they said they didn't or something. So there's no question that people knew 4.3 was not sustainable. The difference is the timing. We're saying it's not sustainable now, you're saying it's not sustainable till 2006, and that's the difference. The 4.3 is not sustainable. Actually, if you listened to the Ontario Federation of Agriculture yesterday, they said the same thing. Virtually every briefing we've had has said exactly the same thing.

Mr Klees: You don't have to argue the point with me that a rate cap is not good for the market. I'll be the first one to support that. What I'm saying to you is that it's a matter of what that exit strategy is when the rate cap comes off, and what the effect is going to be on the stakeholders, on the consumers, on the various vulnerable people we have subjected to this new-found Liberal policy, which is to immediately pop this rate cap. I would have been one, and was one, as my colleagues know, to argue for an exit strategy that would remove that rate cap as soon as possible, prior to 2006, when it is reasonable.

If you look at the policy, it was to ensure that we have the generating capacity in place, to ensure that we have competitive rates coming forward into the marketplace. I don't see your additional generating capacity in place today. I don't see it in place at the time that this rate cap policy you're proposing today will be in place.

My point is very simply this: I think it's a mistake. I think it's a mistake, first of all, to come forward with a policy that does not protect the very people the original policy your party voted for intended to protect.

I warn you today that you will have people at your door. I say to the parliamentary assistant, you will have people at your door, whether it's the farming community, whether it's seniors, whether it's people in your own constituency. When they get the bill, you know the bill will be much more than just the \$20 or \$30 you're projecting, because you have not calculated into that all the additional costs for delivery charges and what the LDCs will do with the new-found latitude you're giving them in this legislation. I warn you, you will have seniors coming to you and you will have small business people coming to you saying, "Ms Cansfield, we cannot pay this bill." And at that point in time it will be too late, because you will have set in motion a policy that is irreversible in time to save people from financial difficulty. That's the warning I want to put to you.

I know what the mantra is. The mantra is the cap hasn't worked because it cost \$800 million. Folks, you're here fresh from where you came from. The only thing I'd caution you against is, don't fall into the trap of coming in, whether it's simply to a committee here or going into the Legislature, and just taking the notes that are given to

you from the ministry or from your political staff at the Premier's office or in the minister's office. Don't fall into the trap of simply repeating what you're told to say. Keep in mind why you came here in the first place. You came here to protect the people who elected you. You came here out of a motivation to make government better, to bring truth to government. I compliment you for that. It's not an easy road; it's very tough. Your biggest enemy in this place, I'm telling you right now—Ms Wynne smiles—are the very people you need to work with. Challenge them on the issues before you simply recount word for word what you're told.

This mantra of the cap having to come off because the cap didn't work is empty rhetoric. The cap was never meant to work revenue neutrally within a year. It was intended to average out over a period of time, to 2006, aided and abetted by the generating capacity and the settling down of a marketplace. That was the original intention.

I would much rather you say, "Yes, we made the promise. Frankly, it was an irresponsible promise, and we're not going to keep that promise, because now we've changed our mind." That's straightforward. I can buy that. I understand it. I think it's unfortunate, but it's simply saying, "We made a mistake." Why don't you just say that? That gives traction.

I'll leave that, but I think it's important as you move forward that you simply take this on. I shouldn't give you this advice, but you'll get a lot more credit as individual members of the Legislature, and, frankly, you'll get more credit as a government if you just simply say, "The promise was irresponsible. We realize it was an irresponsible promise. We're breaking it because we think there's a better way to go." That I can buy. Don't carry on with this mantra. Your minister has spent a lot of time in this place and he's picked up some bad habits along the way. Don't you do the same.

1050

The Chair: Thank you, Mr Klees. Mr Kormos, do you have further questions or comments?

Mr Kormos: That's sort of like being lectured by your delinquent uncle after he's released from the pen, telling you not to smoke, drink and hang out at pool halls. But in any event, the fact is that your delinquent uncle has good advice to give, notwithstanding that he just did four years for armed robberies.

Interjection.

Mr Kormos: Exactly. As long as he goes to his meetings, he's going to be on the straight and narrow.

I should have asked you this when I was talking to you before, Mrs Cansfield, the parliamentary assistant. Is this new proposal going to be revenue-neutral?

Mrs Cansfield: No. People are going to pay, as we've already indicated, the price of electricity. To sustain the cap is irresponsible.

Mr Kormos: But the new cap: is it going to be revenue-neutral?

Mrs Cansfield: It's not the same plan that was put forward, because you based your plan on the fact that the

money generated out of OPG would pay down the debt. The fact of the matter is, they generated zero this year. So it's not the same plan.

Mr Kormos: I understand it's a different plan. That's why it's an amendment. Is it going to be revenue-neutral?

Mrs Cansfield: All this is going to do is lift the rate until the Ontario Energy Board puts in a regulated market by May 1, 2005. This is the first phase of a long-term strategy dealing with electricity issues in this province.

Mr Kormos: Your government isn't implementing a new cap?

Mrs Cansfield: Well, 4.7 to 5.5 is a cap.

Mr Kormos: That's right, so it's a new cap. Is this cap going to be revenue-neutral?

Mrs Cansfield: The cap is only on until April 1.

Mr Kormos: I understand. Is it going to be revenue-neutral?

Mrs Cansfield: I guess I don't understand what you're asking.

Interjection.

Mrs Cansfield: It's actually going to reflect the price of the electricity that people use; 60% of the households use about 1,000 kilowatts per month.

Mr Kormos: I understand. Is this cap going to require subsidy, as the current cap requires subsidy?

Mrs Cansfield: Yes.

Mr Kormos: Yes, it will. How much?

Mrs Cansfield: I don't know how much it would be.

Mr Kormos: You've got to know those things.

The Chair: Would you prefer to have staff answer this question?

Mrs Cansfield: No. Actually, it was one of the things that I didn't remember. It's the fact that, with the price rate, if the price goes down, the differential will be rebated back to the consumer. But it won't be rebated in terms of a cheque. In all probability it would go on to their bill.

Mr Kormos: What's anticipated?

Mrs Cansfield: It's anticipated that we've erred on the high side of the price of electricity and that there would be a rebate.

Mr Kormos: So you're anticipating a rebate?

Mrs Cansfield: As the market stands now, with the price of electricity.

Mr Kormos: So you're basically overcharging consumers?

Mrs Cansfield: No. What we're doing is trying to find something that's realistic and that reflects the true price of electricity. As you and I both know, that market is very volatile, isn't it? It goes up and down.

Mr Kormos: But in the planning process, you are telling me that you expect this to be a cap that results in a rebate at the end of the road.

Mrs Cansfield: We're hoping it will be revenue-neutral, but if it turns out that there is money, it will be returned to the consumer. That was indicated in the minister's opening statement.

Mr Kormos: So you're saying at least it's going to be revenue-neutral, possibly even with the prospect of a rebate to consumers.

Mrs Cansfield: That's right. We hope so.

The Chair: OK, Mr Kormos. Mr Hardeman, do you have questions or comments?

Mr Ernie Hardeman (Oxford): On the same issue, I was under the understanding as I read the bill and reviewed it on behalf of my constituents that what the government was doing was increasing the cap. In your opinion, the process, although you promised to do it, is not sustainable, so we're going to raise the cap. The major difference in this legislation is to raise the cap. I'm going to assume from this that you are raising the cap to be more realistic so it will average out, with the open market, that the price that people are paying across the board from day to day will, at the end of the year, pay for the total amount of energy they consume.

Mrs Cansfield: That's correct. The difference is that we erred on the high side, so that if there is any change—

Mr Hardeman: I guess that's really my problem on behalf of my constituents. I'm going to be honest about it. A lot of my constituents are having real concerns about removing the cap, because they were promised that until 2006, 4.3 cents was all they would have to pay.

They are also realistic, and they realize that eventually someone is going to have to pay for the power they use. They say, "I can understand that someone would come forward with a plan to make sure that whatever we're doing in this province is sustainable." But it's a real problem when I have to explain to people that "Not only are we going to try to make sure this is sustainable, but we've made special efforts to put the cap high enough, so we're going to charge you more than the power is worth. If that's not so, if we are way over, we'll give some of it back, but in the meantime you're going to have to pay 5.5 because we may see some increase. We may not get the type of conservation we had hoped, we may not get the type of investment in generation we had hoped, so that may be the cost, on average, at the end of the time frame. So you go ahead and pay 5.5 until we decide whether that's too much, and if it's too much, we'll give it back to you."

Mrs Cansfield: It might be 5.4; it might be 5.52. You and I both know the spot market is volatile, and that's one of the reasons why the OEB will be the regulator for a market price by May 1, 2005. So you have to take a good estimate. It isn't an extreme estimate. It was an estimate based on the current market at the time the bill was written. The minister indicated that if the energy price goes lower, that would come back in the form of a rebate to the customers. I don't understand why this is a difficulty, because you're not looking at an extreme of four or five cents; you're looking at points. It may very well be that if it's higher, we'll absorb the difference; if it's lower, it goes back to the customer.

Mr Hardeman: I guess my concern is based on your comment that, "We erred on the side of being too high."

Mrs Cansfield: Well, of being cautious.

Mr Hardeman: My constituents aren't prepared to have their hydro bill be set based on, "We erred on the side of being too high, and if it is too high, we will rebate it, maybe."

Mrs Cansfield: You and I both know, if you were to explain to your constituents, that you don't have a solid price for electricity, that the spot market is volatile. It goes up and down; it peaks and valleys. So you can't give a consistent—

Mr Hardeman: I guess my problem is that I did explain that to my constituents a number of months ago when we all agreed, both sides of the House, that 4.3 cents until 2006 was going to be that number, and they agreed with me. Now we're saying, "No, no, we've seen the first year of that." As everyone knew, and as was explained by my colleague, the first year it was going to cost a lot of money, but by year four of the same process, the generation and sale was going to be lower than the 4.3 and it was going to pay some of that back.

The government has decided that in their opinion that's not the case, so we're going to have to increase the floor price. That's really what this bill is all about. So they increased the floor price and then we had the parliamentary assistant saying to this committee, after the presentation was made by all the people—incidentally, the federation of agriculture didn't say they agreed with just raising the price to 5.5. Their point was quite clear. They wanted a two-tier pricing system that would at the end of the day bring it back down to 4.3 cents, which they're presently paying. For the farming community, that's where they believe the average will come.

I think that's really where I have my concerns about your comments that "We are erring on the side of being too high and that we will rebate it if we need to." They believe that if you price it properly at value and on time of consumption and so forth, the price will be at 4.3. They don't believe they should pay 5.5 for the first year and then find that half of them have gone into bankruptcy because they can't afford to pay their hydro bills and then find out, "I'm sorry—well, it's actually good news, isn't it, folks? You're going to get some of this back, because we didn't need to charge 5.5; we only needed to charge 4.5 to make it work." I'm really concerned that you're setting it at the high end and expecting my consumers to pay that, and if you're wrong give it back.

1100

Mrs Cansfield: Again, if you read the bill, it says 4.7 and 5.5 based on the usage. You cannot give an absolute in the electricity market. I'm sure you also told your constituents about the debt load and the fact that the policy wasn't working and that the cap was not realistic and that they were paying prices for electricity that couldn't be sustained—because certainly I said that to my constituents.

Again, I'm telling you, we've heard from a variety of people that they wanted the cap lifted, and it's had extraordinary support. The government has put in place a policy whereby they have started an initial phase into a long-term strategy for electricity pricing in this province. The final market price will be the responsibility of the Ontario Energy Board, which has to come, I think, by May 1, 2005, with a regulated price that will be non-politicized, so that people in fact can have a determined

market value and it's not volatile. That was stated over and over again by Mr Duncan, the minister.

Mr Hardeman: Just to finish off, I, the same as every other member from both sides of the House, told my constituents that we were going to keep the cap till 2006. I didn't do that as a Conservative member. Every person, including the individual who ran in Oxford for the Liberal Party, made the commitment to our community that the 4.3 was where it was going to be till 2006. That's what I told them and yes, we did explain, as I'm sure you did, that that policy was creating a debt in the fund because in the first year it was not the price of hydro. I think everyone knew that. It was on the Internet; it was a common thing. You could check every hour the price of power being bought and sold.

So yes, I did tell my consumers that, and they even understand that times change and that things are a little different and that maybe you could do a market analysis on it now and say, "No, 4.3 cents is not the right number. We can't make that sustainable, even over that period of time. We've done this consultation and we've investigated it, and everybody in the know understands that that's not going to be able to be done."

To help me and tell my constituents, I would like to know what it is that we found out—just in the hydro market, not in the general provincial budget; this never was part of the general provincial budget—that changed between the time that my good friend was saying, "We will keep that promise and we will cap that hydro rate"—what changed to when we came to Queen's Park and we had a new government and they decided, "No, our word is not our bond. We have found all this information out as it relates to the hydro market that says we can't make this sustainable." I'd like to know what it was that made that decision, that it was worth breaking your promise, because I think you're a person of great integrity and I think you'd want to keep that promise, but you've decided you can't. I'd like to know what information you have that says you can't keep that promise.

Mrs Cansfield: Essentially, people in Ontario have been paying an unrealistic price for electricity. The true cost of electricity has not been reflected in the cap. Virtually all parties have agreed the cap is unrealistic. The difference is the timing. You cannot continue to sustain the debt. No matter where you place it, ultimately the taxpayer in Ontario pays for it. If you continue with an unrealistic cap, you continue to raise the debt. That is not responsible government, especially when I consider listening for years to a government that kept saying they were going to get rid of and eliminate the debt.

The fact of the matter is the debt has increased; it has increased substantively. To sustain a policy that continues to do that is unrealistic in being a good, fair, responsible government for the people of Ontario. As much as they want to reflect true costs in their electricity—and we've heard that consistently—I can tell you the other that I have consistently heard, and I'm sure others here have, is that they do not like debt either. So there's your answer. The fact of the matter is there's a

policy in place that is not sustainable. The cost of electricity did not reflect the true costs, and we're dealing with it in a responsible way.

Mr Hardeman: One final comment. I keep hearing—and the parliamentary assistant's doing it continually, relating the issues we're talking about here with the cost of the rate cap in the hydro regime. We're equating that with the other finances of the province. Is there an intent of the government at some point in time to use the excess of the 5.5 to help pay for other services in government? Is the hydro consumer at some point going to be asked to have their rates cover the costs of some of the other promises that we're presently having trouble keeping?

Mrs Cansfield: The consumer will be asked to deal with the true cost of electricity and to work with this government on the demand side in terms of finding ways and means to conserve electricity, so that instead of being the highest consumers in the world of that particular commodity, we may in fact be one of the lower ones.

The Chair: Mr Jackson and then Mr Kormos.

Mr Jackson: My question is for staff. On Monday I had a meeting with one of your ADMs, Mr Pospisil. He was very helpful and informative. At the time I had asked him, as I did the minister yesterday, for a more detailed breakdown of the mitigation fund as it relates to the net effect of the cost of the subsidy on a month-by-month basis. I was wondering if you came today prepared to share that with us, as I was advised we would have access to that information.

Ms Lawrence: I'm afraid I don't have that with me, but I will follow up with Mr Pospisil and make sure that's delivered this afternoon.

Mr Jackson: There have been several questions raised about the assumptions that staff made in advising the government. Clearly, the minister lacks the expertise to tie down the number of 4.7 cents or 5.5 cents; this would have been generated by the ministry. Are any of you before us today in a position to advise how those caps were arrived at?

Ms Lawrence: We can bring in the economists for a more detailed explanation, but I think in part they are based on price projections from market participants and independent consultants, who suggest that over the near term, in the coming months, the price will range from about 4.7 cents a kilowatt hour on the low end to about 5.8 cents a kilowatt hour on the high end. The 4.7 cents that was chosen for the first 750 kilowatt hours is very much the low end of that price forecast. It's also close to what the market price has been in year two of market opening since May 1 of this year, which is on average about 4.8 cents, I believe. The 5.5 cents is roughly half-way between the 4.8 cents we've seen so far in year two and the 6.2 cents average price in year one of market opening.

Mr Jackson: Can you advise this committee as to the full costs of mitigation to date, since it was a piece of retroactive legislation to place the cap on? Remind me of the date of that, and do you have the breakdowns of the cost to the consolidated revenue fund of the province of Ontario for those periods?

Ms Lawrence: I don't have the breakdowns with me; we'll have to bring those back.

Mr Jackson: But do you know the net amount?

Ms Lawrence: The net cost of the program has been about \$800 million.

Mr Jackson: Over how many months?

Ms Lawrence: Since market opening.

Mr Jackson: Which was?

Ms Lawrence: May 1, 2002.

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Mr Jackson: So you will be prepared to provide what the annual, had this cap stayed in place—you would be in a position to give us the projections as to what that would cost in this fiscal year, which expires March 31, 2004, and you'd be in a position to give us your projection, should this current legislation remain, of what your ministry is advising finance in preparation for its budget numbers, which we know is currently occurring?

Ms Lawrence: We will ensure that there's someone here this afternoon who can provide a more detailed breakdown on costing and financials.

Mr Jackson: Thank you.

The Chair: I'm just wondering, is it possible to get that information before we recess at 12 o'clock?

Ms Lawrence: We can try and round it up right now.

The Chair: It would be my preference that we do that. Mr Jackson, are you finished your questions?

Mr Jackson: Yes, thank you, Chair.

Mr Kormos: It's interesting, because you talk about the cost of the cap going back to the opening of the market on May 1, 2002, yet the cap wasn't enacted until all hell broke loose with consumers out there, and was done in the fall, just prior to the winter season.

The Chair: Mr Kormos, we may have sent the person out of the room who may be able to provide you with the answer.

Mr Kormos: We have. I'll be darned.

The Chair: I think it was just a coincidence. You surely can keep going, but I think the person who will be answering your question is on the phone in the hallway right now. I leave it in your hands.

Mr Kormos: I should ask the parliamentary assistant. We're going to get back to that in just a minute. You understand what I'm asking. You say the \$800 million is attributable to that whole period of time. But as I recall, there were some phony rebates: "The cheque's in the mail?" What was it, \$100?

Ms Kathleen O. Wynne (Don Valley West): It was \$75.

Mr Kormos: So it was a token, a gesture of a rebate that was retroactive. It wasn't a pure retroactivity of the rebate, because there wasn't a calculation, was there?

Mr McCann: I think Ms Lawrence is trying to establish the facts to bring back before the committee. I don't have them, and I think we should let her do that.

Mr Kormos: Yes, we're going to wait for her.

Now, Ms Parliamentary Assistant, going to the regulations—because the regulations are referred to in both parts of this amendment in section 1, both subsection (5)

of section 78 and subsection (5.0.1) of section 78. First of all, can you tell us whether the regulations have been drafted? I suspect not.

Mrs Cansfield: No, they're not drafted.

Mr Kormos: And that's not unusual. Can you tell us what the situations will be that are referred to in subsection (5)?

Mrs Cansfield: The type of regulations that can be made? Is that what you're asking?

Mr Kormos: The situations. Subsection (5) refers to "situations." The regulations will outline those situations.

Mrs Cansfield: I'm sorry. I've got two different section 5s here.

Mr Kormos: Section 1 of the amendment, which—

Mrs Cansfield: Right. Of the amendment, you're looking at?

Mr Kormos: Section 1 of the amendment, which amends—

Mrs Cansfield: It says "the consumer holds a valid registration number"—are you looking at that amendment?

Mr Kormos: Section 1 of the amendment, of your bill.

Mrs Cansfield: This amendment? Ah, the act. OK. I'm sorry. I thought you were speaking to the amendment.

Mr Kormos: Well, no. Your bill is an amendment to the act.

In section 1, it refers to subsection 78(5), which is replacing the repealed subsection 78(5), and then it refers to subsection (5.0.1). Both of them refer to the regulations. Subsection (5), which is going to be reinserted back into section 78, talks about "situations," describing the different situations. What are those different situations that the regulations will be addressing?

Mrs Cansfield: I'll ask the legal counsel.

Mr Kormos: I think it's important for us to know. It's not an unfair question, by any stretch.

Mr McCann: First of all, I should point out that these regulations will apply to section 78 of the legislation, which is the general authority of the Ontario Energy Board to make rates. So the situations could be many different types of situations. I think "situation" is a broad word. But, for example, in the regulation-making power itself, which is in section 11(g.4), it talks about situations being defined with reference to amounts of electricity used and times when electricity is used. So you could, for example, have what I think are referred to as time-of-use regulations that could deal with a rate structure that had different rates depending on the time of day, and the amounts of electricity could refer to, for example, the blocked prices that we've talked about, up to a certain number of kilowatt hours per month. The significance here is that that system would be brought forward to the Ontario Energy Board, which would then be required to build in the structures in fixing just and reasonable rates under section 78.

Mr Kormos: My concern is that we're buying a pig in a poke here. Without those regulations, exactly what is it that this bill is going to do for consumers via the Ontario

Energy Board? Do government members have any of the same difficulties I have in buying a pig in a poke in this regard? If we don't know what those are, as staff rightly told us, it could be anything from basically soup-to-nuts situations as a very broad definition. Gosh, Chair, is it prudent to pass legislation without knowing what its real impact is going to be? I put that to you.

The Chair: I don't think it's my role to answer that, but thanks for the question anyway.

Mr Kormos: I was looking to you for leadership and direction.

The Chair: I'm ensuring the progress of the business of the committee, including yours. I think you're doing a wonderful job.

Mr Kormos: You're going to be frustrated at 12 noon, because it's over then. She's gone. You know that?

Mrs Cansfield: I think what it's trying to do, and my colleague is correct, is be more sensitive to the needs in terms of times and amounts. It deals with such things as interval metering, identifying types of consumers. It's not unusual, obviously, for a bill to be passed and then the regulations to come. I've been around long enough to know that much.

Mr Kormos: But when that used to happen, Liberals used to be joining me in squealing and howling and talking about jackboot governments.

Mr Kim Craitor (Niagara Falls): I never did that.

Mrs Cansfield: I never did that either.

Mr Kormos: You weren't here. When Mr Gravelle was on committees with me, he would echo my declarations of jackboot tactics on the part of the government and oppressive anti-democratic strategies and using the force of the majority to ram through legislation when they, the government, the Tories, didn't even know the impact it was going to have.

Maybe I'm just a creature of habit, but I'm concerned now that we're being hoodwinked here. Maybe if the parliamentary assistant could assure us that some of the situations will be addressed. For instance, depending upon the time when you use your electricity—what's that phrase?

Mrs Cansfield: Time of use.

Mr Kormos: Time of use. Can you assure us that time of use is going to be one of the situations addressed?

Mrs Cansfield: What I can assure you is that those types of options will be looked at, and that's why there is provision here to give us the authority to deal with those particular kinds of situations. Looking at interval metering, there are different kinds of metering; there's not just one.

Mr Kormos: I get the message. This is a "trust us" bill. You couldn't trust them for what they promised during the election campaign. Gosh, I'm worried now. Hold on to your watches and your wallets, folks.

Ms Wynne: In the bill, in section (g.4), it says that the situations are defined with reference to amounts of electricity used and times when electricity is used. There's no need for the parliamentary assistant to reassure you that those are the definitions of the situation. It says it in the

legislation, and then the regulations will further define the times. But it refers to those things in the legislation.

The Chair: Mr Kormos, any further questions before I go to Mr Hardeman?

Mr Kormos: Yes, just the one. I want an assurance that regulations will be put forward and what those regulations will address. That's precisely the point.

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Mrs Cansfield: I agreed and I said to you that the regulations will provide the authority to deal with those types of situations and with the consumers. It says it specifically in here, and I'm just saying to you there are a variety of options that are out there in terms of time of use, interval metering, high loads, peak loads—those kinds of things.

Mr Kormos: "Trust us," she says.

Mrs Cansfield: We do have rather good people working for us.

Mr Kormos: They were working for the Tories for the last eight years too.

Mrs Cansfield: Different direction, though.

The Chair: Mr Hardeman, do you have questions or comments?

Mr Hardeman: Yes. I wholly support the need for regulations to allow certain things to be recognized, like time-of-use and interval meters. We have one of those prepaid meter systems in my riding. It works very well for conservation. Presently the legislation doesn't allow for those to be recognized, and I much appreciate that being put forward.

As I'm sitting here listening to debate, I'm having some real concerns as to how far the regulations could go in allowing the energy board to totally disregard the cap altogether. Could the time of use be 24 hours a day and the defined consumer be everyone, and all of a sudden we have, by regulation, eliminated the process of capping? That would be of concern to me, as to how broad that regulatory power is, that we could now supersede the main body of the legislation by defining the whole marketplace as special circumstances and removing the cap. I'd just ask someone from staff to assure me that that's not possible.

Mr McCann: I think under section 78 of the Ontario Energy Board Act, the board has a very broad power of a quasi-judicial nature to hold hearings to determine rates. I just say that by way of background.

The purpose of the regulation here would be to structure the board's approach to that in some manner so that the regulation—I think the fairest thing to say is that the regulation would provide a certain structure as to how the board set rates in terms of these situations, time-of-use and tiered pricing. I don't think the regulation-making power is drafted so broadly that it could be used to—

Mr Hardeman: To clarify, if six months or three months into this process the Minister of Energy decided—we've seen the change in the last three months in the position of the Minister of Energy. If he has that same change of heart in the next four months and decides that he wants to eliminate caps altogether, can he pass a

regulation that allows that to go to the energy board without it coming back legislatively, and eliminate the cap totally?

Mr McCann: As we'll see, I guess, in other sections of the bill, the rate jurisdiction, if I can put it that way—the jurisdiction to fix rates for all aspects of the distribution of electricity—can be returned to the Ontario Energy Board very quickly, if that were to be the decision that's made. At that time, the board would in fact have authority over all aspects of rates, including the commodity price aspect. So I guess you could say that wouldn't be a cap. But what I think is important to realize is that the Ontario Energy Board's authority is to fix just and reasonable rates, which is a phrase that has a long history in the regulation of energy in Ontario. It's intended to be a rate that's fair to all participants.

The Chair: Mr Hardeman, anything further?

Mr Hardeman: That's fine.

The Chair: Mr Klees?

Mr Klees: To the parliamentary assistant, I heard you say earlier that it's the government's intention to move to a regulated market by May 1, 2005. My question is the definition of that. In your opinion, where does that leave competition in the marketplace, if you in fact are moving to a regulated market?

Mrs Cansfield: The minister, in the bill, asked that the Ontario Energy Board, by May 1, 2005, have the responsibility to come up with a fair market price for energy and a determination of how that would happen. Mr Weston will undertake to do that. That is part of the request of the bill. So in terms of that kind of definition, you'll have to wait until the Ontario Energy Board holds its hearings and comes up with its fair and just approach to finding, as we said, a nonpoliticized market price for energy.

Mr Klees: The definition, though, of a regulated market versus a deregulated market is very substantive. There is a huge difference. In a deregulated market we have open competition; we have an opportunity for competition. We have retailers now involved who invested literally billions of dollars in this province; we have companies that have in the hundreds of thousands of customers. What I'm hearing you say is that essentially by 2005 those companies will be put out of business in the province of Ontario.

Mrs Cansfield: No, that's not what I said at all. That's on the generation side. On the generation side, if you listened to what the minister had indicated, there is a task force that will be reporting that actually has all of the renewable, the four different types of generator folks on this. It has been meeting for some time and will, I think, come to conclusions by the end of December for the minister that will deal with the supply side and options. I think you also heard the minister say that there would be a panel—I'll call it a blue ribbon panel, my term—of people in the electricity sector to give advice, and you also would have heard him say that there is a place for both public and private in dealing with generation.

My remarks earlier were just to speak to what the responsibility of the Ontario Energy Board would be, but

in terms of the generation, that's all part of what will be forthcoming in the new year.

Mr Klees: Actually, I'm not speaking about generation at all; I'm speaking about retail. I'm speaking about commodity price to the consumer.

When you say there will be a regulated market, which is what caught my attention, I think we need some clarification. Are you talking about a regulated market for the commodity to the consumer? Are you talking about a regulated market for wholesale? What are you talking about?

Mrs Cansfield: I apologize; it's my error. I didn't mean to suggest to you that it was a regulated market in terms of a fixed-price commodity. That's not what the Ontario Energy Board is supposed to do. It is to be regulated by the energy board but it is not a regulated market, so in terms—I apologize. The terminology is new. The acronyms are—there's a litany of them. What I meant is that they have the responsibility for dealing with it in a regulated way, but it's not a regulated market. That is May 1, 2005; they have that. It could be earlier, but that's the determination date.

Mr Klees: We'll cut you the slack on that, but you understand that there are really huge implications—

Mrs Cansfield: Yes, I appreciate that, and I also appreciate that you did cut me a little slack on it. It's a very complex industry and, as I said earlier, there are no quick-fix solutions here. You have identified, and justifiably so, many people who will be impacted and affected. I think it's important and prudent for all of us to take that into consideration as we move forward. I'm hoping there will be those opportunities to listen, and listen wisely.

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Mr Klees: Just one last comment on this: From the conversations we've had, I think it's becoming obvious to everyone that essentially what we have here, as my colleague put it, is really another cap, a raised limit on the cap in the interim until you get to the next phase of your policy. You also, of course, are still exposed to incurring substantial costs to the taxpayer, because if in fact the actual price of electricity—and it is possible that we could end up with another set of circumstances that spike these prices. Who knows what it might be? God forbid, but it could happen. If in fact that does happen, the same kind of unexpected circumstances converging, it could very well be, even under this revised cap you're putting forward, that the cost to the taxpayer could be an additional \$600 million. Would you agree?

Mrs Cansfield: I could paraphrase what I've read, and I concur with it and it's something I've heard consistently in all the briefings, and that's the fact that there wasn't action by the previous government, and that there's a waning of private-public sector interest in the generation side in Ontario—and that's on the supply side—while exposing the province to its financial obligations far in excess of the direct cost of the retail price freeze. In essence, again, it wasn't sustainable. We were sustaining a debt, but at the same time, we were not encouraging the generation that needs to occur. By lifting

the cap, by putting in the interim until April 1, we have sent a signal to the community that generation is very much a part of the government's agenda.

Mr Klees: Ms Cansfield, I understand that very well. Essentially, what you're doing with this legislation is actually accelerating the privatization of generation in the province—which, by the way, I have no objection to. In fact, I believe in and have been an advocate in the past for the need for the private sector to step into the marketplace and help with building the generation capacity in this province. What essentially you have done and are doing with this legislation is that you're accelerating what we as a government were intending to do over the period of time to 2006. The reason we moderated that time frame was because we wanted to ensure we had put in place the appropriate consumer protection mechanisms so that we don't have a fallout in that period of time while there might be those spikes.

My caution to you is that by listening to the stakeholders who are saying to you, "Yes, we'll come into the province of Ontario. We will build the generation. We will go into public-private partnership arrangements with you," or whatever, by accelerating that time frame, as you have done, you are putting at risk not only the groups we referred to earlier, but you're also putting at risk the taxpayers of the province of Ontario.

You speak eloquently about the need to do this because of the debt, the \$800 million that has been created in this fund that's there to even out the costs. I suggest to you, and I believe your advisers will tell you, and the consultants and the energy experts will also tell you, that circumstances could well happen this coming year, that this cap that you have in place could cost you half a billion, \$800 million. Is it possible?

Mrs Cansfield: I think the comments earlier around trying to find a price between the 4.7 cents and 6 cents—that was something that the economists and the people within the ministry indicated would be fair in terms of finding a cap that we could set—

Mr Klees: The same economists, by the way, who gave advice to the previous government about the 4.3-cent level.

The Chair: Let Ms Cansfield finish her—

Mr Klees: I thought she was finished.

Mrs Cansfield: That's OK. I acknowledge that they're the same folks. The difference is that debt is debt, and you cannot sustain it. The true cost of electricity was not being reflected, so we were not encouraging people to conserve. Actually, our consumption in electricity has gone up by 20%. We have to look at those factors. What is sustainable?

Mr Kormos: Chair?

The Chair: Is this a point of order?

Mr Kormos: No. It's a response and a question to Ms Cansfield.

The Chair: OK. I don't think you're on the list right now. I certainly will go to you when your turn comes.

Mr Kormos: Then it is a point of order.

The Chair: OK. I can't wait to hear it.

Mr Kormos: If this government keeps heating Queen's Park with electric space heaters, like we've got here behind us—

The Chair: That is not a point of order, Mr Kormos.

Mr Klees, I interrupted you. Do you have any further questions?

Mr Klees: I think I'm pretty well there. I wanted to get confirmation, which I got, from the parliamentary assistant that the taxpayers, under this scheme that's being put forward, are still very much at risk; that it's a matter of providing a level of protection, which is why they've built a staging into this process. They do recognize that there should be some level of protection. They're simply saying, "Well, we're going to lift the ceiling. We are going to abandon some people in the process." But this government knows full well, as the same consultants and industry experts advised the previous government, that it's very possible that they're going to now be facing the same potential of incurring additional debt for the taxpayer. This is not Nirvana here. They haven't pulled the rabbit out of the hat to solve the energy challenges that we've got in this province.

I'll wrap up my comments by saying that no one agrees more that we need a good exit strategy from a cap. No one agrees more that we need to have incentive in this province for additional generation. I certainly agree that there's a role for the private sector to play in that building of generation capacity and that there's a role, obviously, for the private sector and competition to play on the retail side as well.

My concern with this legislation the government is putting forward is its timing and its unwillingness, really, to admit that there are vulnerable people who are going to be negatively affected by the acceleration of the time frame.

It may well have been that we would be ready to do this at the end of 2004 or 2005, once we know that we have additional generation coming on stream so that we can begin to see the marketplace functioning and we have some confidence that the capacity's there, that there will be a balancing of the marketplace. That is why we are bringing forward some amendments here: to hopefully build some of that protection in. We hope that the government will be receptive to those, and we'll carry on.

The Chair: Mr Jackson, would you like to ask your questions again? It appears we have the person here who may be able to answer them, if you could maybe summarize the questions for the benefit of us all.

Mr Jackson: The questions are the ones I raised the other day with respect to what the actual cost is to the consolidated revenue fund for the mitigation strategy for the 11-month period from May 1, 2002, to March 31, 2003. What is the actual? And what is the actual for April 1, 2003, to October 31, 2003? That would be a seven-month measurement; I suspect that is the measurement that Erik Peters looked at. Therefore, what was the 12-month projected for April 1, 2003, to March 31, 2004, which would be that fiscal year's impact on the consolidated? To your knowledge, has that final number been modified because of price fluctuation and usage

fluctuation? The first two are actuals; the third one is a projected.

The additional question following on that is what was projected for April 1, 2004, to March 31, 2005, in terms of it, because it matters little the size of the cap; it matters what your projected for the price would be. That would then determine either how much subsidy our government was offering under our cap or how much subsidy the new government is offering under its revised cap.

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Mr Shane Pospisil: I should probably introduce myself. I'm Shane Pospisil. I'm assistant deputy minister, Ontario Ministry of Energy. Mr Jackson and I had a good meeting the other day. We spent a couple of hours going through Bill 4, and there are a lot of questions, and obviously there are a couple more again today. Having missed the context of the previous discussions, I take it we've talked a little bit about the rationale behind the Electricity Pricing, Conservation and Supply Act that was passed last November, fixing the commodity price of electricity at 4.3 cents a kilowatt hour. Obviously, what Bill 4 aims to do is set out a new two-block pricing structure that will replace that.

The 4.3-cent price cap that was actually put in place last November on the commodity cost has created a fairly significant fiscal pressure for the government. It's coming from two areas: first, the fact that the market price of electricity has been considerably higher than the 4.3-cent cap; and second, the government's commitment to honour the retail contracts that were out there at the time. There are two pressures there that have to be dealt with.

In terms of market prices since market opening, Mr Jackson, I walked you through some of these numbers the other day. In the first year since market opening, the average price was 6.2 cents a kilowatt hour. So the legislation last November had a fixed price of 4.3 cents. Generators were continuing to get the market prices, which averaged 6.2 cents a kilowatt hour over that period. I think those numbers probably underscore the fiscal impact in year 1. Year 1 did have some severe weather patterns associated with it, both in the summer—I think we all remember the summer of 2002, some fairly long stretches of very hot, humid weather. The winter was very cold weather. Further compounding the problem was return-to-service delays in some of our nuclear capacity, so we had tightness in supply and we had very severe weather. Again, the average price over that first year market opening, the 12 months, was 6.2 cents a kilowatt hour. Again you can relate that back to the 4.3 cent cap and instantaneously see the pressure.

In the second year since May 1, 2003, we've been running about 4.8 cents a kilowatt hour, reflecting again the fact that the weather hasn't been as severe. We've seen some capacity come back on stream. The 4.8 cents a kilowatt hour on average is still higher than the 4.3-cent cap.

Getting back to the essence of the question that was raised—and these numbers I'm going to give you are from the Ontario Electricity Financial Corp, which really

gets into the details of this. Mr Jackson, they would be the source of any month-to-month breakdowns you'd look for at a later date, but the overall numbers are from the OEFC. The total cost of the price freeze to November 1, 2003, is \$1.74 billion. Part of this cost has been offset by a previously planned rebate from Ontario Power Generation in the market power mitigation agreement, which is a proportioned rebate that OPG provides for market prices over and above 3.8 cents a kilowatt hour. It's a very complicated arrangement. We could probably arrange a couple of hours to walk you through that if you're interested. There is a rebate that offsets that \$1.74 billion, and the net cost to the government is \$800 million from May 1, 2002, through to November 1, 2003. So in response to the magnitude of the fiscal pressure, at a gross level it's \$1.74 billion and net it's \$800 million.

In terms of looking out over the next several months—and I think we're all aware too that in the original program that was introduced last November, certainly the positioning on the program was that over the four-year duration of the program market prices would eventually even up and it would be neutral over the four years of the program. I'm giving you numbers for the first 18 months of the program, and it's obviously not neutral: \$1.74 billion is not neutral; \$800 million net cost is not neutral.

In terms of looking out over the next couple of years, all we can do is look at the market prices we see unfolding in Ontario's electricity marketplace. We've looked at a scenario where the market price averages at 5 cents a kilowatt hour; that's one of the scenarios we've looked at. The 5 cents a kilowatt hour would lead to another \$300-million cost in each of the next two fiscal years. Obviously, if someone wants us to model 4.8 cents, 4.7 cents or 5.5 cents, we can certainly do that. But we've looked at 5 cents a kilowatt hour in each of the next two fiscal years, and the cost associated with that, given the current formula and structure of the program, is \$300 million in each of the next two years.

Just a general comment as well in terms of where the ministry sees prices over the next couple of years; we're not a forecasting group, but obviously for part of the exercise behind Bill 4 we relied on some external forecasts. There are a lot of people out there who do this for a living, some very reputable forecasting agencies. We've seen numbers for the next year to 18 months in Ontario anywhere from 4.7 cents to 4.9 cents a kilowatt hour. We also know the risks associated with severe weather patterns. We saw that in year 1 since market opening, where the average price was 6.2 cents a kilowatt hour; that's hot, humid summers and then colder than expected winters. That's obviously a contingency we have to plan for.

When you look at the incremental costs of new generation that's going to be coming on stream in Ontario, we're typically looking at natural-gas-fired generation, cogeneration facilities. The cost of bringing that incremental supply on stream right now is 6 cents to 7 cents a kilowatt hour. That's not unique to Ontario; those numbers would be similar in Alberta. You're bringing on new gas-fired generation, and gas prices are set in the

North American market. We kind of know what the capital and construction costs are, and a lot of folks on Bay Street would tell you that the cost of that power right now is going to be 6 cents to 7 cents a kilowatt hour.

So when you look at the price range we've set in the two-block structure, the rationale obviously for the lower end, 4.7 cents, relates to what we've seen the last number of months with moderate weather patterns both summer and winter and also given the existing supply-demand fundamentals we see; so that's the lower end of the spectrum. When you look at the 5.5-cent block price we've set, obviously that's reflecting where we've been in the first year. It's probably a little lower than where we were in the first year, but it's also looking ahead to the cost of incremental supply coming on stream in Alberta; that's where the market is. We think the two blocks we've picked certainly fit within that forecasting range. At the end of the day should we look at ourselves having a surplus, that's going to be credited back to consumers after the first year through the OEB mechanism.

So again, when you look at our block price structure, the two prices we've set, 4.7 cents and 5.5 cents, certainly fit within that forecasting parameter and some of the work we've done in that area. Again, the forecasting range we've been operating in, dealing with some of the private sector forecasts and looking at the cost of incremental supply, is 4.7 cents to 5.8 cents.

It was just pointed out to me that I said our forecasting range was 4.7 cents to 4.9 cents. The broader range we're operating in is 4.7 cents to 5.8 cents. That's the forecasting range, obviously the 5.8 cents reflecting severe weather patterns and the 4.7 cents is kind of where we've been over the last number of months.

The Chair: Mr Jackson, do you have further questions?

Mr Jackson: I still am seeking the answer as to what the impact is on the consolidated revenue fund, the 11-month period. How much of the \$800 million over 18 months came off the province's books ending March 31, 2003? That was my question. How much has the current cap cost this year, in-year, fiscal year to date? I suspect that number is closer to \$300 million is all it's costing taxpayers this fiscal year and not the \$800 million, which would be misleading, because that is the accumulated effect of a measurement inside the four-year period. I'm just wanting to get an honest assessment of what this cap is costing us currently if we're going to move to a new cap, which begs the other question I raise, which is, what is the difference between 4.3 and 4.7 in terms of moving that cap, and what will its impact be? You can project that number based on consumption, because it has nothing to do with the price you're going to charge. I simply ask you how much it will cost to subsidize between 4.3 and 4.7.

1150

Mr Pospisil: Just in response to your first question, again, what is the fiscal impact from May 1, 2002, to November 1—

Mr Jackson: March 31, 2003. You need to speak to us in terms of the bills we pay as the government. If

we're going to hear the words "deficit" and "debt"—we have to deal with the government's deficit and debt each year. We know that we balanced the books. The current Treasurer Sorbara has admitted that he balanced the books with the first year of the cap. So the government was able to meet its responsibilities to balance the books with the most expensive period of time for this cap. It is less costly to taxpayers, if we want to use it in that context. It has been less of a cost since April 1, 2003. The committee needs to know because of the revenue-neutral claims that were made by the previous minister and your ministry with respect to what the impact was on the consolidated revenue fund. That's really what I want to get at here. I'm not challenging that the accumulated net effect is \$800 million. I want to know, how much was the first 11 months of the program? If that was \$550 million and the last seven months is only \$250 million, that I'd like to know.

The Chair: OK, so the figure you want is from May 1, 2002, to March 31, 2003. That's the first figure you want.

Mr Jackson: Well, I want all three. I read all three into the record. Then I would request the difference between 4.3 and 4.7.

The Chair: Let's go through them one by one. The first figure requested is from May 1, 2002, to March 31, 2003.

Mr Pospisil: We're going to have to go back. In terms of how we track that information within the ministry—and I would say the same is probably true for our colleagues over at the OEFC—we track everything on an annual year relating to the market opening date of May 1, 2002. You'll notice a lot of the data I presented are from May to May. So that's the format in which I have the information today. We can certainly slice and dice the numbers and get them to you over the time frames you're looking at. That would really be a task for the Ontario Electricity Financial Corp.

Mr Jackson: With all due respect, the first two numbers currently are in the hands of the Ministry of Finance. These are actual payouts. These are already reported in the books. That's all I'm asking. I just assumed that they did you the courtesy of advising you how the \$800 million was broken down. I have to assume that they are involving you before they pay this bill. I don't think our number crunchers over in finance were sitting there, poring over the database from the esteemed group you've referenced who do projections. This is based on the actual payout for hydro, correct?

Mr Pospisil: Yes.

Mr Jackson: So the actual payout by the treasurer of Ontario to subsidize this is a matter of public record. I'm hoping you're aware of this, given that you're advising the minister of the day about where to place this cap, and the treasurer needs to know in advance what the exposure of the government of the day is in this area. We're moving the cap. We will reduce that exposure. But this committee has the right to know to what extent is the exposure.

Mr Pospisil: I think at one level, Mr Jackson, I've answered that question. I've just answered it over a slightly different time frame than the specific question you're addressing. I've given you numbers for May 1, 2002, to November 1, 2003; I've given you a net amount of \$800 million. In response to your question, "How much does it cost?" I've given you a gross number over that time frame; now you're asking me to provide information on some breakdowns of that, which we will endeavour to do. I do not have those with me today. We can certainly do that. That is public information. It's available; we can respond very quickly. I just don't have the exact numbers for those specific time frames. We can get them to you, no problem.

The Chair: Thank you. Mr Jackson, is there anything further?

Mr Jackson: When can we anticipate somebody in energy calling finance to clarify these numbers? It is within your purview and responsibility to be able to give this committee a number between 4.7 and 4.9; I dare say you can probably work it out with a pencil and paper. When can we anticipate having that?

Mr Pospisil: I think we can have something to you by the end of the day.

Mr Jackson: Before we—

The Chair: We're meeting again at 4.

Mr Jackson: We need to know that before we approve the actual number.

Mr Pospisil: What you're going to find with the question you're asking—I've given you the overall numbers. Now I'm probably going to give you a couple of different sets of numbers that, when you add them together, will add up to the \$800 million; or on the gross side will add up to the \$1.74 billion.

Mr Jackson: Let me make a subjective comment. The question has to be raised, as a public policy question, the degree to which the actions contained in Bill 4 will impact the provincial budget. That's a fair statement. We are in no position right now to be able to give an answer—there's no one in this room; nor has the minister at any point indicated what the exposure of the government is under the new rate regime. We have not heard what the current in-year exposure is—never once—and we've asked for it. At the press conference, the minister was asked the question; he said, "I'll get back to you with that."

We need that information to determine whether or not the—we're taking on faith that the 4.7 to the 5.8 number will achieve a certain revenue-neutrality or it will achieve something closer to the projected true rate of the cost of buying electricity. We've had no financial information to confirm that fact. Nor have we had a presentation other than to suggest that in the opinion of some experts out there, that's where the rate would be. You've given us gross rates, and it's quite fascinating. We've gone from 6.2 to 4.8. That is a huge difference when you've got a cap at 4.3. If the rate drops to below 4.5 or 4.7, we could be going through this entire upheaval and the cost to the government to do the upheaval can hardly be justified,

save and except that the purpose of this bill then becomes not to adjust the price, which we're subsidizing, but to allow the local distribution companies to come in and pick up their billion dollars as quickly as possible. That would in effect be the whole purpose of this bill. And that is not what the government's intended purpose, or stated purpose, was with this legislation. It was that consumers pay a higher rate, but if that real rate is going to be as close to the 4.3—so that is why we need to know what the cost projection is of the difference between 4.3 and 4.7. That's a fairly reasonable request and not hard to figure out, given that you've been playing a blended rate of 4.8 for the last seven months. We need those numbers and we need them right away.

Mr Pospisil: We'll endeavour to get those different time frame numbers back to you as soon as possible. We'll have to work through the Ontario Electricity Financial Corp, which has the specific mandate for that.

One point of clarification, Mr Jackson: The forecast range we have is not exclusively based on the expert advice we've received from these forecasters I referenced. Again, when you look back at average prices in the market over that time frame, we've got 12 months in the first year at 6.2 cents. We don't need forecasters to tell us what that was; the marketplace has told us that's where it was in year one. Again, that was 6.2 cents. We've seen 4.8 cents a kilowatt hour since May 1, 2003. It's not a forecaster telling us that; it's the marketplace telling us that's the average over that time frame.

We would expect that those two benchmarks—year two really shows us a year with moderate weather conditions—

Mr Jackson: Shane, with all due respect, you're repeating yourself. I took university statistics, as you did. So we can agree. If you can get me the numbers, I'm not going to need a tremendous amount of assistance interpreting them as a politician.

The Chair: You've undertaken to get those numbers.

Mr Pospisil: Yes.

The Chair: We've got about two minutes left. Cam, there are a couple more questions. You can keep going if you like.

Mr Jackson: Prior to his arrival, in the initial request for information I stated that I wanted to know what your projected forecast numbers are that you have to give your ministries—not you specifically—that you send over to finance so that finance can, in the budget, determine what its potential exposure is. That's a requirement. There is a number, a base number, which was provided and that finance has, that explains what the potential exposure is for this fiscal year. In tandem with that is the actual. I asked earlier that I would like to know what the advice to finance was, what would be the projected number and what the actual is, and see just how far our variances are.

That's a legitimate question because it will show us the degree to which both your ministry and finance understand the impacts of the mitigation. It's unfair to indite a cap with a number which in its first year was hit fairly severely—there have been no reports in the media of how light the impact has been in the last few months.

You'll recall from our meeting on Monday, and my conversation with the minister on three occasions publicly, the mitigation strategy actually has been, in specific months, revenue-neutral. In fact, there was a \$100,000 amount to the positive in terms of how the mitigation strategy works. I believe this committee deserves the right to know that. If I were a Liberal, I'd want to hedge myself ever so slightly if I thought for one moment that moving this cap higher was essentially going to move the market price higher artificially, because the effect of a cap is to have a chilling effect on the price. We know that's happening out there.

The Chair: It's 12 o'clock.

Mrs Cansfield: Chair, just before you close, I'd like to make a very quick comment. I'd like to thank the staff for being here and being available. I don't need to mention it to everyone, but obviously staff are here to provide good advice, and you do. The government makes the policy of the day, as did the previous government. You are professionals, and your responsibility is to give us your very best advice, and that you do as well. I know, as I said and reiterated earlier, it's complex. There are no quick-fix solutions here. Your advice has been good and it's sound. I would just like to put that on the record and thank you for your support and for helping to answer the questions.

It's unfortunate that we didn't have an opportunity, since the previous government knew that we had a short period of time that you had agreed to—if we'd had that request along with your amendments, maybe we could have saved a considerable amount of time this morning.

Mr Jackson: Point of order, Chair.

The Chair: There is no point of order. It's recess.

The committee recessed from 1203 to 1602.

The Chair: We can call the committee to order again. As per the time allocation motion passed by the House on Thursday, December 4, 2003, the standing committee on justice and social policy shall meet at the call of the Chair for two days for the purpose of public hearings and clause-by-clause consideration of the bill. The committee may meet from 10 am to 12 noon and again following routine proceedings until 6 pm on each of the two days. At 4 pm on the second day, those amendments which have not yet been moved shall be deemed to have been moved and the Chair of the committee shall interrupt the proceeding and shall cause there to be one final 20-minute waiting period for the purpose of calling in the members and shall then immediately, without further debate or amendment, put every question necessary to dispose of clause-by-clause consideration of the bill. The committee shall report the bill to the House not later than the first sessional day that reports from committees may be received following the committee's second day of consideration of the bill.

In the event that the committee fails to report the bill as provided in paragraph 6, the bill shall be deemed to have been passed by the committee and reported to and received by the House.

As it is now 4 pm, I shall recess the committee for 20 minutes and then I will put the questions.

The committee recessed from 1603 to 1623.

The Chair: If we can call the committee back to order, we are on section 1. Shall section 1 carry?

Mr Kormos: I want a recorded vote, please.

Ayes

Brownell, Cansfield, Duguid, Gravelle, Wynne.

Nays

Jackson, Klees.

The Chair: The section is carried.

Shall section 2 carry? Carried.

Shall section 3 carry? Carried.

Shall section 4 carry? Carried.

We are now on section 5.

Mr Jackson: We have an amendment.

The Chair: Subsection 5(1) of the bill, subsection 79.4(1.2) of the act. Shall the amendment carry?

Mr Jackson: I should move it.

The Chair: I think they're deemed to have been moved already.

Mr Jackson: We'd like to speak to the amendment. Are you moving the Conservative Party motion that would amend subsection 5(1)? That is the one that is before us.

The Chair: My understanding is that amendment is now on the floor. It's deemed to have been moved and it's on the floor. You don't, unfortunately, have the ability to speak to it.

Mr Jackson: Don't tell me this is in the programming motion?

The Chair: I'm sure you'll find it is. It's not my programming motion; it's the programming motion we've been given.

Mr Klees: I'd be interested in seeing it.

The Chair: Absolutely.

Mr Michael Gravelle (Thunder Bay-Superior North): On a point of order, Mr Chair: I just want to be clear. Are we now voting on the Conservative Party amendment or are we voting on the section of the bill? I want to be sure we understand that.

The Chair: What we will be voting on are the amendments to section 5 of the bill.

Interjection.

The Chair: That's right. They're introduced by Mr Jackson.

Mr Gravelle: I just want to make sure all the members are clear on what we are voting on.

The Chair: We'll do them individually, and then we'll go and vote on section 5, either as amended or as it exists now.

Dealing with the first amendment to section 5, that's subsection 5(1), subsection 79.4(1.2), shall the amendment carry?

Mr Jackson: This is a recorded vote.

The Chair: Do you want a recorded vote?

Mr Jackson: I want all of our amendments recorded.

Ayes

Jackson, Klees.

Nays

Brownell, Cansfield, Craitor, Duguid, Gravelle, Wynne.

The Chair: The amendment is lost.

Moving on to subsection 5(1), subsections 79.4(1.3) and (1.4), shall the amendment carry?

Interjection.

The Chair: We're dealing with the second amendment, and you want a recorded vote for each and every one of them?

Mr Jackson: Yes, please.

Ayes

Jackson, Klees.

Nays

Brownell, Cansfield, Craitor, Duguid, Gravelle, Wynne.

The Chair: That amendment is also lost.

Mr Klees: Mr Chair, while I realize there is no debate on this, I wonder, just for the benefit of the committee, if the parliamentary assistant would mind providing a rationale for their voting against this particular amendment.

The Chair: I don't think I would entertain that at this point in time. I'm trying to stick to the rules we've been given. The next time we go through this process, perhaps we should all pay a little bit more attention to the rules that have been given to us. At this point in time I'd prefer that not take place.

Mr Klees: I think we've got lots of time, actually.

The Chair: The point I'm trying to make is that I can't.

Mr Klees: By unanimous consent?

The Chair: I don't think you have unanimous consent, and I don't think we can override instructions from the House by unanimous consent in any event. I'm not trying to be difficult.

Mr Duguid: How does the parliamentary assistant know why I'm voting against this amendment?

The Chair: This is interesting, but the point is there is no debate in this particular circumstance. We're dealing with subsection 5(1), subsections 79.4(1.5) and (1.6).

Mr Klees: Recorded vote.

Ayes

Jackson, Klees.

Nays

Brownell, Cansfield, Craitor, Duguid, Gravelle, Wynne.

The Chair: That amendment is lost.

Shall section 5 carry? All those in favour? Opposed? That section is carried.

Shall section 6 carry? All those in favour? Opposed? That section is carried.

Shall section 7 carry? All those in favour? Opposed? That section is carried.

Section 8: Shall section 8 carry? Those opposed?

Section 9: Shall section 9 carry? Opposed? Section 9 is carried.

Section 10: Shall section 10 carry? Those opposed? That is carried.

Section 11: We're dealing with an amendment to subsection 88(2.4) of the act. Shall the amendment carry?

Mr Klees: A recorded vote, please.

The Chair: Recorded vote.

Ayes

Jackson, Klees.

Nays

Brownell, Cansfield, Craitor, Duguid, Gravelle, Wynne.

The Chair: Shall section 11 carry? Those opposed?

Moving on to section 12: Shall section 12 carry? Those opposed? That is carried.

Section 13: Shall section 13 carry? Those opposed? That also is carried.

Section 14: Shall section 14 carry? Those opposed? That carries.

The long title: Shall the long title of the bill carry? Those opposed? That carries.

Shall Bill 4 carry?

Mr Jackson: A recorded vote.

Ayes

Brownell, Cansfield, Craitor, Duguid, Gravelle, Wynne.

Nays

Jackson, Klees.

The Chair: The motion carries.

Shall I report the bill to the House? Those in favour? Those opposed? That also carries.

Thank you very much. We are adjourned.

The committee adjourned at 1632.

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of Ontario**

First Session, 38th Parliament

**Assemblée législative
de l'Ontario**

Première session, 38^e législature

**Official Report
of Debates
(Hansard)**

Monday 16 February 2004

**Journal
des débats
(Hansard)**

Lundi 16 février 2004

**Standing committee on
justice and social policy**

Commitment to the Future
of Medicare Act, 2003

**Comité permanent de la
justice et des affaires sociales**

Loi de 2003 sur l'engagement
d'assurer l'avenir
de l'assurance-santé

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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON
JUSTICE AND SOCIAL POLICY

Monday 16 February 2004

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

COMITÉ PERMANENT DE LA JUSTICE
ET DES AFFAIRES SOCIALES

Lundi 16 février 2004

The committee met at 1305 in room 151.

The Chair (Mr Kevin Daniel Flynn): I'd like to call the standing committee on justice and social policy to order.

Before we hear from the Minister of Health and Long-Term Care today, I'd like to deal with the report of the subcommittee that's before you.

SUBCOMMITTEE REPORT

Ms Kathleen O. Wynne (Don Valley West): Mr Chair, I'd like to move the report of the subcommittee report.

Your subcommittee on committee business met on Tuesday, December 23, 2003, and recommends the following with respect to Bill 8, An Act to establish the Ontario Health Quality Council, to enact new legislation concerning health services accessibility and repeal the Health Care Accessibility Act, to provide for accountability in the health service sector, and to amend the Health Insurance Act:

(1) That the committee meet for the purpose of a briefing with the minister, his parliamentary assistant and ministry staff on Monday, February 16, 2004, starting at 1 pm.

(2) That the committee meet for the purpose of holding public hearings in Sudbury on February 17, 2004; in Ottawa on February 18, 2004; in Windsor on February 19, 2004; in Toronto on February 23, 24 and 25, 2004; and in Niagara Falls on February 26.

(3) That the committee clerk, with the authority of the Chair, post information regarding the hearings on the Ontario parliamentary channel, the committee's Web site and one day in a local French- and English-language daily in Ottawa, one day in a local French- and English-language weekly and daily in Sudbury, and one day in a local English-language daily in Windsor and Niagara Falls.

(4) That interested people who wish to be considered to make an oral presentation on Bill 8 should contact the committee clerk by 12 noon, Monday, February 9, for Sudbury, Ottawa and Windsor; by 12 noon Monday, February 16, for Toronto; and by 12 noon, Thursday, February 19, for Niagara Falls.

(5) That on Monday, February 9, by 4 pm the committee clerk supply each of the subcommittee members with a list of all the potential witnesses who have

requested to appear before the committee in Sudbury, Ottawa and Windsor.

(6) That on Monday, February 16, by 4 pm the committee clerk supply each of the subcommittee members with a list of all the potential witnesses who have requested to appear before the committee in Toronto.

(7) That on Thursday, February 19, by 4 pm the committee clerk supply each of the subcommittee members with a list of all the potential witnesses who have requested to appear before the committee in Niagara Falls.

(8) That, if required, each of the subcommittee members supply the committee clerk with a prioritized list of the names of witnesses they would like to hear from by 4 pm, Wednesday, February 11, for Sudbury, Ottawa and Windsor; by 4 pm Wednesday, February 18, for Toronto; and by 4 pm Monday, February 23, for Niagara Falls. These witnesses must be selected from the original list distributed by the committee clerk to the subcommittee members.

(9) That the committee clerk, in consultation with the Chair, be authorized to schedule witnesses from the prioritized lists provided by each of the subcommittee members. The number of witnesses per party is a ratio of Liberals, two, Conservatives, two, NDP, one.

(10) That if all groups can be scheduled in a given location the committee clerk, in consultation with the Chair, be authorized to schedule all interested parties and no party list will be required for that location.

(11) That the minimum number of witnesses to warrant travel to any location be six.

(12) That groups and individuals be offered 30 minutes in which to make a presentation. The committee clerk, in consultation with the Chair, may reduce this time to 20 minutes in order to accommodate more groups if demand exceeds availability.

(13) That on February 16, 2004, the minister be invited to make a 30-minute presentation, followed by 90 minutes of questions and answers to the minister or his parliamentary assistant and ministry staff. The time per party is Liberals, 35 minutes; Conservatives, 35 minutes; NDP, 20 minutes.

(14) That the research officer prepare a summary of what other provinces have done regarding health councils, including the opinions of various medical and hospital associations and the financial impact on the various jurisdictions; a review of the Romanow report recommendations regarding the mandate of the National Health

Council and how they translate provincially; a summary of the testimony heard.

(15) That the deadline for written submissions be 12 noon, Friday, March 5, 2004.

(16) That amendments be filed with the clerk of the committee by 5 pm, Monday, March 8, 2004, if the committee is to meet for clause-by-clause on Tuesday, March 9, 2004.

(17) That the committee meet on Tuesday, March 9, 2004, for clause-by-clause consideration.

(18) That the parliamentary assistant, the opposition critic and the third party critic each have five minutes for opening statements at clause-by-clause.

The Chair: Ms Wynne has moved the adoption of the subcommittee report. All those in favour? Those opposed? The motion is carried.

**COMMITMENT TO THE FUTURE
OF MEDICARE ACT, 2003**
**LOI DE 2003 SUR L'ENGAGEMENT
D'ASSURER L'AVENIR
DE L'ASSURANCE-SANTÉ**

Consideration of Bill 8, An Act to establish the Ontario Health Quality Council, to enact new legislation concerning health service accessibility and repeal the Health Care Accessibility Act, to provide for accountability in the health service sector, and to amend the Health Insurance Act / Projet de loi 8, Loi créant le Conseil ontarien de la qualité des services de santé, édictant une nouvelle loi relative à l'accessibilité aux services de santé et abrogeant la Loi sur l'accessibilité aux services de santé, prévoyant l'imputabilité du secteur des services de santé et modifiant la Loi sur l'assurance-santé.

The Chair: We move to the Minister of Health and Long-Term Care. Welcome. The floor is yours.

Hon George Smitherman (Minister of Health and Long-Term Care): Thank you. Good afternoon. It's a privilege for me to be here to address this committee on the first day of public hearings on Bill 8, the Commitment to the Future of Medicare Act. This is a piece of legislation which is very important to the government and to me, and I want to make sure that we get it right.

The purpose of Bill 8, broadly stated, is to protect essential health care services and to ensure that our public health insurance system remains publicly funded and publicly administered. This bill will preserve the sacred principle that Ontarians should have access to medically necessary health care services based on need, not on ability to pay.

The Romanow report affirmed that health care services are a right, not a privilege. We agree wholeheartedly with Roy Romanow, and we believe the right to health care deserves to be preserved in law.

Romanow proposed that in order to modernize the foundations of medicare, a sixth principle, accountability, should be added to the Canada Health Act. Ontario's Bill

8 would entrench accountability as a cornerstone principle. This bill, and our commitment to the principle of accountability, is Ontario's contribution to strengthening medicare in Canada. I'm very proud that Ontario is leading by example.

1310

I would say at this time as well that accountability is a two-way street, and I'm prepared to take some accountability unto myself. This bill, as presented, is a bill that does not reflect the best tone. As a result of the work we've done subsequent to its presentation, we've worked with stakeholder groups and will be bringing forth a wide variety of amendments which will have the effect of creating a better and more appropriate tone for the foundations of the future of medicare in the province of Ontario. I take personal responsibility for that, both for the sending of the bill that was presented at first reading and for the amendments that will follow.

I'd like to acknowledge today in particular committee Chair Kevin Flynn and committee Vice-Chair Jim Brownell. I'm pleased to recognize my legislative colleagues from all parties; my parliamentary assistant, Monique Smith, who will be here to help work this bill through committee; my legislative assistant, Abid Malik, who will travel with the bill; and a variety of staff from the ministry. Today, I'm joined by George Zegarac, the assistant deputy minister from the integrated policy and planning division, and while this bill travels about, Pearl Ing, the manager of institutional program units from the program policy branch of the ministry, will be available. I would encourage you, when you have questions or concerns, to work those through with any staff who are around.

I'd like to thank you for the work you're undertaking, because in many ways, the heavy lifting of government is done here in committee. While question period gives us all the chance for a few fireworks, when we move to committee hearings such as this, a very different dynamic can take over. I welcome this non-partisan spirit, a spirit that was evident during the committee on general government's hearings on Bill 31, the Health Information Protection Act. The amendments we agreed upon strengthened Bill 31, and amendments that we will table and others that will be offered during these hearings can strengthen this bill too.

We acknowledge the need to improve some areas of the bill to better achieve the intent of the legislation: to strengthen medicare in this province. It's clear we didn't get the tone of the bill right in some areas, as I mentioned earlier. For example, the penalty provisions are too harsh. I accept that, and I want to confirm that we have listened to concerns about the penalty provisions and will be adjusting them.

We have listened to concerns that have been brought to us, and we welcome hearing many different viewpoints over the next few weeks. I have already made specific commitments to amendments. Amendments will be officially tabled on March 9, when the committee reviews the bill clause by clause. So I also welcome a vigorous review of Bill 8.

None of us has all the answers. I certainly don't. In fact, I've led discussions with the Ontario Hospital Association and the Ontario Medical Association on their desired changes, and we've made lots and lots of progress through honest dialogue. Ministry staff have been involved in constructive discussions with them and with other parties too. The work of this committee and the input of Ontarians will help us refine and improve the legislation and narrow the range of differences. At the end of the day, some differences will remain. Frankly, for a bill based on values, that shouldn't come as a surprise.

Then there's CUPE. Bill 8 can't open collective agreements, and unions have never been subject to accountability agreements, but we've agreed to make that more explicit.

We also welcome input on the regulations to make sure we get them right. With the Health Information Protection Act, we introduced the concept of a 60-day consultation period on regulations. We've had a lot of support for this approach, and the committee may want to consider a similar option for Bill 8.

We'd like your views about whether there's an opportunity to more explicitly define aspects of the bill in legislation rather than through regulations. When we consider the legislation and regulations, we all must remember that Bill 8 needs to adapt and respond to changes in the health care system. It must be a living document, but it must also offer enduring protections for our values.

Now I'd like to tell you a little more about this bill and what it means to our government. I've said on numerous occasions that medicare is the best expression of Canadian values. Our medicare system, a system that has evolved over many years, gives life to our compassion, our fairness and our generosity. I don't think I'm overstating the case when I say that medicare helps to define who we are as Canadians. As a Canadian, I'm proud of our medicare system, and as a Liberal, I'm committed to doing what I can to improve and protect medicare. This bill sets out to do just that.

And let's be clear: Our medicare system is in need of protection. In recent years, various forces have been chipping away at medicare, eroding its principles, narrowing its reach, watering down the protection it gives to our citizens and lowering the quality of the care it delivers. Our government is determined to reverse that trend and to lead a drive to improved system performance.

I think we all share the fundamental goal of Bill 8 to protect essential health care services in Ontario. How we achieve it is a more complex challenge.

Let me tell you a bit more about the basic principles that guided our work. These principles are expressed in the preamble, the bill's values statement.

We believe that Ontarians deserve a legal and binding commitment to a universal, publicly funded health care system.

Like the Romanow commission, we believe that the health system must be consumer-centred and based on need, not ability to pay.

We believe that the health system is the whole of its complementary parts. It was anchored on the foundation of hospitals and physician services, but to be relevant, it must evolve to encompass a full continuum of care, including primary health care, home care and pharmacare.

We believe that the future strength of Ontario's health system depends on providers, government, citizens and communities sharing responsibility and working together. It depends upon system integration.

We believe that our health care system must produce improved outcomes, and we believe that greater accountability is at the heart of these improvements.

These principles were our starting point. Now let me tell you a little more about how we will accomplish our mission.

Bill 8 contains three key components.

First, the bill establishes the Ontario Health Quality Council, which will have responsibility for reporting on important health care indicators in an effort to raise the quality of our health system.

The government has a clear plan to transform health care in Ontario. Our commitment is no less than to make Ontarians the healthiest Canadians, and we are committed to ensuring all Ontarians have effective access to quality health care in every setting. Our plan for better health care means strengthening all parts of the system and bringing them together into one integrated system that encompasses family health care, home care, community services, hospital care, emergency services, long-term care and pharmacare.

The council's mandate would be to measure the effectiveness of the system and to report on its performance in priority areas. Our government would work with the council to determine the real measures that mean something to Ontarians.

The council would report to the people of Ontario about wait times for important procedures; for example, cardiac care and hip and knee replacements. The council would monitor and test the effectiveness of the system through broader measures like population health status and the prevalence of serious and preventable diseases such as diabetes. It would track rates of physical activity, obesity and smoking.

Ontarians need to know about the quality of care they are receiving. It's their right. By measuring results of Ontario's health care priorities, the council would ensure government is accountable to the people we serve.

The health quality council exists to serve the broad and diverse interests of our citizens. Its purpose is to enhance quality outcomes in our health care system. It needs to be composed of individuals with superior knowledge of the health system, and it needs strong representation from people drawn from our communities.

According to some people's vision, stakeholder groups should be appointed to the council so they can represent the various silos that are all too evident in our health care system, but we see it differently. We've made sure that the council does not advance individual stakeholder agendas but allows for the broadest perspective

possible to advance the agenda of our most important stakeholders: 12 million Ontarians who are counting on all of us.

The second key component of Bill 8 is that it would strengthen the prohibition of two-tier medicine. It proposes amendments to the Health Care Accessibility Act and amendments to the Health Insurance Act. These amendments have one simple and clear purpose: to strengthen the ban on two-tier medicine in Ontario by closing legislative loopholes.

Two-tier medicine can take many forms; for example, queue-jumping and extra billing. One recent example of queue-jumping was a clinic that allowed people who were willing to purchase an enhanced lens for cataracts to get cataract surgery immediately, while all other cataract patients had to wait a year for the same surgery. If we subscribe to the values and principles I mentioned at the beginning of my remarks, then we cannot and we will not tolerate this kind of activity. When it comes to health care, there is only one kind of Ontarian.

We want Bill 8 to slam the door on pay-your-way-to-the-front-of-the-line health care. How would we do this? The bill would require mandatory reporting of unfair activities like queue-jumping and extra billing and would offer protections to whistle-blowers so that these activities can be stopped.

It would ensure the future of medicare in Ontario by enshrining in law the belief that every member of our society has an equal right to quality health care, based on need, not money. The bill outlaws insured individuals getting faster medically necessary treatment based on ability to pay.

There have been concerns raised regarding the relationship between the privacy provisions of Bill 8 and Bill 31, the Health Information Protection Act. I've had the opportunity to speak with the member from Kitchener and health critic for the Progressive Conservative Party around this issue.

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Let me be very clear: Bill 8 is subject to the enhanced privacy protections in Bill 31, the Health Information Protection Act, that has received first reading and gone through the standing committee hearing process. Bill 8 explicitly states that the general manager of OHIP could collect personal health information only in extraordinary circumstances in order to investigate serious violations that harm patients, such as queue-jumping or extra-billing. And let me be clear about one more thing when it comes to privacy: We will strike down any reference to the minister collecting health information.

The third key component of Bill 8: It would entrench accountability as a central principle in Ontario's health system. I've said on numerous occasions that we have to make our health care system more accountable. By "accountable" I mean making sure that the government and our health partners clearly agree on what outcomes we need to achieve together. Too often, health care providers are working in isolation, losing opportunities to share information and work in a complementary way. It's

time to actually transform our health care system into a system. Accountability means being answerable for our actions, not just our good intentions. We need clearer performance targets, greater transparency and better lines of communication.

And let me be clear: Accountability isn't a burden we simply place on others. It's a responsibility we all accept and share, and I include this government and my ministry. Bill 8 is a big step toward greater accountability in the system. It creates a framework that allows the minister to establish negotiated accountability agreements with publicly funded health resource providers. The health care providers we intend to designate in the bill are hospitals, community care access centres, long-term-care facilities and independent health facilities.

The bill does not apply to solo physicians, group practices or labour unions. We will offer amendments that make that abundantly clear. Boards and CEOs hold positions of great honour and great responsibility. They are entrusted not only with managing precious public health care dollars but with ensuring high-quality care for the people they serve. The ministry would establish accountability agreements with the board of directors, and the board is then required to establish a similar performance agreement with the CEO. We will be introducing amendments which will clarify the process for entering into accountability agreements.

Accountability agreements would ensure targets are met in key deliverable areas such as access, quality and safety. There are provisions that would link compensation with key deliverables, and we would expect a board to hold its CEO accountable for failure to meet deliverables.

The intent here is not to take away any of the authority of the governing executive boards, but to clarify our expectations for deliverables. But Bill 8 also makes it clear that a CEO in charge is not only responsible to the board but to members of the public as well. In the end, only if all other recourse fails and only in exceptional circumstances can the ministry impose penalties directly on the CEO. We have worked very hard with the Ontario Hospital Association to achieve an acceptable middle ground.

It should also be noted that these accountability agreements and compliance directives would be made available to the public. After all, it's the public interest that we're working to protect.

Some have told us that there is an opportunity to lay out the processes for accountability agreements more explicitly in the legislation so that the language more clearly achieves the bill's intent. This too is an important matter for the committee to consider.

Lastly, labour unions may tell you that the accountability agreements will allow for opening collective agreements. This bill does not reduce or change any of the protections that currently exist in any of our labour laws. It does not allow anyone subject to an accountability agreement to reopen collective agreements. Unilateral wage rollbacks and unpaid days off might be the record of a previous government, but the suggestion by

anyone that Bill 8 enables this is an act of partisan-inspired fiction.

The Canada Health Act was passed unanimously by Parliament in 1984. It is this spirit of common values and purpose that I hope will guide the committee during this hearing for Bill 8.

The Canada Health Act expresses our country's fundamental commitment to a universal, accessible, comprehensive, portable and publicly administered health insurance system. I view this as one of the most important pieces of government legislation of the past quarter century. The Canada Health Act aims to ensure that all residents of Canada have access to necessary hospital and physician services on a prepaid basis. It provides the provinces and territories with conditions that they must satisfy to qualify for their full share of federal transfers under the Canada health and social transfer. However, the Canada Health Act does not include the principle of accountability. Our government's proposed Commitment to the Future of Medicare Act would entrench accountability as a cornerstone principle of Ontario's health care system.

As public servants, each one of us recognizes the importance Ontarians place on accessible quality health care. This bill will help to ensure that health care is available to all Ontarians in every community in the province now and for generations to come. By identifying the principles that are important to us and by acting firmly and decisively to protect and apply these principles, we can make real progress in providing health care today and in the future.

I'm excited about the progress we're making in transforming and improving health care, and I'm committed to the principles and values enshrined in Bill 8. I look forward to hearing from the people of Ontario on this important piece of legislation, and I look forward to hearing the ideas and recommendations of this committee and working with the membership of this committee to strengthen this important bill. Thank you very much.

The Chair: Thank you, Minister. I understand you'll be with us till a quarter after two. Is that correct?

Hon Mr Smitherman: Yes.

The Chair: What I propose to do, then, to make sure that all parties have equal access to you, is split that time by the same proportion till a quarter after two, and then from a quarter after two until the time we adjourn, we will split that also proportionately, if that meets with the pleasure of the committee. OK. We'll start with the official opposition.

Mr Frank Klees (Oak Ridges): Minister, thank you for taking the time to be with us today. It's encouraging, at the outset. I might say it's encouraging to know that you've obviously heard from many stakeholders regarding their concerns and you've indicated that you've already committed to a specific number of amendments. I'm assuming that you have those amendments available to you.

I would ask, in the interest of the work that this committee has been asked to do over the next couple of

weeks, whether it's your intention to provide the committee with a copy of those amendments so that we at least know what you have committed to, so that as we move through our discussions, we don't have to be covering the same ground. I can tell you there are many, many concerns on the part of stakeholders regarding, as you put it, not only the tone but the substance of this bill. I think it would be a huge waste of time of this committee if, with all of the delegations that we'll be hearing from, we have to take under advisement their concerns. So my question to you is: Would you be prepared, in light of the fact that you clearly have already made some specific commitments perhaps to stakeholders, to have those regulations or those amendments for this committee as well, as soon as possible?

Hon Mr Smitherman: What I said in my remarks was that we'd make those amendments available at the point where the committee is prepared to do clause-by-clause.

We've met with some stakeholders and exchanged some language—in some cases they provided us with language—but on some of these, where there are multi-stakeholders affected by language in the same provisions, I wouldn't say we've settled exactly on language, to the point where I think it's incredibly important that we be informed by the work of the committee and by what we hear from the presentations of stakeholders. I could commit to you to try and advance that timetable, but I'm not in a position today to provide you with language for all the amendments that we would presume to bring forward on March 9.

Mr Klees: It would certainly be helpful, Chair, for us to receive from the minister at least an outline, then, with regard to the subject matter of the sections the minister is considering amendments for. It would be very helpful, in light of the fact that the minister has those, if we could have those in time for the beginning of our hearings, starting tomorrow.

Hon Mr Smitherman: I don't think I can commit to having them for you tomorrow, but I'd say if you could give us 48 to 72 hours, we'll provide you with a sort of framework for the areas and sections of the bill where we intend to offer amendment, and the nature or direction we're headed in, but not actual drafting of the proposed amendments.

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Mr Klees: That would be very helpful. I'd like to also take the minister up on his comment. He referred to the process that was followed with Bill 31. The minister will recall that in that particular case, following the amendments, the bill came back to committee for further review. Can the minister give us an undertaking today that that is the process he'll follow here?

Hon Mr Smitherman: I'd be informed on that point by the committee's direction. I think this is a bill that would benefit from more eyes on it. The broader the consideration that flows from that, the better the likelihood of finding a bill that does what we're asking of it. It strikes me that the process we followed with respect to

Bill 31 is a good model, and that's why I commented on it in my remarks. I'd be guided by the direction of the committee, but that strikes me as satisfactory.

Mr Klees: I'll take that, then, as an undertaking from the minister that that will be the process, unless of course someone on this committee would object to that, which I can't imagine. I think it will be helpful, and in fact the appropriate thing to do, particularly given the number of amendments that are being considered here by the minister.

I'd like to challenge the minister on a comment he made, because I think it goes to the heart of this bill. It seems to me that the minister is saying that much of what has gone wrong in our health care system in the past is perhaps the fault of the local boards and CEOs, given that the majority of Bill 8 really deals with clamping down on local boards and CEOs and putting that accountability factor in place, and as this bill was being drafted it seemed to me that the accountability balance certainly was very much against the local boards and the work that the local boards were doing.

The minister obviously is coming back to the centre of the line, from what I'm hearing him say, and it remains to be seen what the amendments say. Could the minister comment on that? And how much of the responsibility would the minister place at the doorstep perhaps of the Ministry of Health and the systems that are in place within the ministry itself to achieve that accountability?

Hon Mr Smitherman: First, I would challenge you in response. Read back to me something from my speech that supports that rather lengthy flight of fancy that you just went on.

Mr Klees: You indicated very clearly, in fact it's in the entire preamble of your bill, that accountability is required. But I read nothing in the entire bill about what the Ministry of Health is going to do to meet the accountability issues. Accountability, as you yourself said, is a two-way street. That's what I heard you say. I would like you to point to me where in the bill the accountability measures are of the Ministry of Health to the public. I haven't seen them. Perhaps I've missed them.

Hon Mr Smitherman: Let me give you three. First, the Ontario Health Quality Council is, first and foremost, a tool of accountability whereby Ontarians will have an opportunity on an annual basis to hold their government accountable for the performance in the system. Second, with respect to the performance agreements that I spoke about, my remarks in the speech, I clearly said that these would be negotiated. Each of the two parties to them, being the ministry and the health service organization, would have responsibility for fulfilling various aspects of them. These are not one-way agreements.

You asked me the question, what's an example of where the Ministry of Health would benefit? I'm mixing words a little. Let me make a point here. I am not someone—and I think you could check this out, I'd say to the member—who has spent a lot of time defending the historic position of the Ministry of Health as it relates to these things, nor am I someone who has had the privilege

or opportunity to spend a lot of time looking in the rear-view mirror.

Here's what I know for sure: On a whole bunch of things where the Ministry of Health has provided funding and sought to achieve enhancements around performance on a public measurement here or there, and I will give you a very specific example in a minute, the ministry over governments—not past Liberal governments or past Conservative governments or past NDP governments, but over time—has had some difficulty in achieving the progress it thought it was paying for.

I'll give you one example from your party's time in office. You spent about \$400 million on a nursing strategy that had as one of its core elements significant targeted enhancements to the percentage of nurses working full-time, and you got next to nowhere on it. I'm just saying that people deserve to understand what the expectations are on them. As an example, in exchange for additional resources, if there is an expectation that we would actually be achieving a higher percentage of nurses, then as a Minister of Health, on a going-forward basis, I'm pretty interested in trying to make sure that we achieve those public policy objectives.

The fact of the matter is, and very clear to all of us, that set against the obvious pressures and expectations that are out there in terms of our health care system, we need to make sure we're achieving our expectations and that we're holding people to account as a result of them in the same way that the public, at the end of the day, is going to hold the government to account for the quality of the health care system in the province.

Mr Jim Wilson (Simcoe-Grey): Minister, certainly I agree with your comments that there is room for improvement in the system and that there is room for better relations, whether through performance agreements or other means, between the Ministry of Health and those providers out there. That's all well-intentioned, I think, as I think your bill is. I just ask, are you not worried? You're on the verge of a doctors' strike in the province of Ontario.

Hon Mr Smitherman: That is the most irresponsible language I've heard from you in a long time.

Mr Wilson: I was watching Global News last night; you're on the verge of a doctors' strike in the province of Ontario, according to one of the OMA executives.

Secondly, one of your employees, one of my best friends, is dying of cancer. George knows him. He worked for me when I was Minister of Health from 1995 to 1998. Since November 3, I and former deputies have been visiting Brian in Scarborough Centenary Hospital, Scarborough General, Mount Sinai and Toronto Hospital—that's the circuit he's been on—and doctors aren't in very good humour. Not to be provocative, and because I'm a former Minister of Health, and I used to have hair before I was Minister of Health too, George—it's a tough job; I feel for you there—but they're not in very good humour. They do see this as provocative because of the money aspects, because of another council. They do see the council as perhaps—because the regulations aren't

out—driving a wedge between them and their patients. They certainly see the unilateral cancellation of block fees, as politically popular as that might be, as something that irritates them at the moment.

You're in fee discussions with them, so I'll ask you a rather friendly question: Could you just tell the committee what you think the mood of the OMA is right now, what you think doctors think about this bill, what they're telling you and what you're telling them.

Hon Mr Smitherman: There are more than 20,000 doctors in the province of Ontario. I travel around to a variety of health care settings and I've had the opportunity to speak with them one on one. Through the course of the time that we've been working to enhance the quality of this bill, I've sensed that there's been a great deal of progress made. At the end of the day this bill is about values. I said in my remarks that not everybody is going to love every element of it, but here's what I know for sure.

I have sat twice in the last two weeks with Larry Erlick, David Pattenden, Ted Broadway and a variety of other officials from the Ontario Medical Association and we've worked toward considerable progress. So what would I say? I'd say that they've seen from a Minister of Health a genuine effort to take their concerns and address those that can be addressed in the context of the values that are in this bill.

What's the mood of the Ontario Medical Association? I assume the mood of the Ontario Medical Association is as it is when you're at the stage that you're in the midst of negotiations. Two Fridays ago at 5 o'clock, after the day's negotiating session had concluded, Larry Erlick and I had a joint dinner with all the members of both sides of the negotiating team and I can assure you that it was cordial. As you well know, and perhaps better, because you had a longer go at it than I've had so far, the tension in health care around resources is always there. What I've tried to do in the slightly less than four months since I became minister is to ask everybody in the health care sector not to set aside the tensions that exist around trying to divvy up the pie, but to acknowledge that the tensions around finances are there, and to look for the opportunities for a sense of common values, to recognize that in health care we all have a real honour to be working in this most cherished of Canadian values. So I sense a lot of progress.

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Let me just correct one thing from your question on block fees. There is no unilateral cancellation of block fees. I'll tell you honestly that this has been a really hard one for me, because these things have been going on for quite a long time, over the course of a variety of governments. I'm not all that keen, frankly, on being the Minister of Health who is seen as giving credence to these block fees, but at the same time the Ontario Medical Association and I both agreed that they've seen some troubling trends around the application of block fees. I think you've heard some of those stories too; we all hear them. So what we seek to do by bringing this into legis-

lation is to give us an opportunity—the ministry, the OMA and the college—to work on making sure block fees are regulated in a way that they're only used for the purposes for which they were intended, not as some modern-day equivalent of key money. Here again, of course, there are some tensions, as there will always be in a complex relationship like the one between the Ministry of Health and the Ontario Medical Association, but I'll tell you I'm very impressed with everybody's commitment to work on it. We've narrowed the gaps considerably.

Mr Wilson: Thank you. I appreciate your answer. I thought I gave long answers when I was Minister of Health.

Hon Mr Smitherman: I get paid by the word.

Mr Wilson: I appreciate it, but I just can't help but think, if the timing is well intended, as your party believes it is with this bill, that you're just—you know the story is out there. When the average physician, the average health care provider, involved in discussions with your ministry now in terms of fees hears this, and it finally percolates out there as it is starting—you're putting salt in wounds right now, and I just wonder about the wisdom of your party and the government introducing this legislation now, when you're right in the middle of what all parties know are such difficult discussions with the OMA on behalf of their membership. If there's a doctor strike, this bill is going to be mentioned. As you can tell by the fact there were at least a few reporters here in the room earlier, people are going to be watching this bill very closely.

I question your timing. I question, as my colleague did, whether the bill actually does what it says it's going to do. That's why Frank is quite right in saying that we need to see the amendments, because certainly what the preamble says doesn't match what many of the clauses say. With that, I think Mr Klees has a question.

Mr Klees: I'm assuming, Minister, that you have a budget for this council. How much is it going to cost?

Hon Mr Smitherman: We haven't yet established a budget for the Ontario Health Quality Council.

Mr Klees: It is going to be reporting to whom? I'm assuming to the Legislature.

Hon Mr Smitherman: To Ontarians.

Mr Klees: So it will be reporting to the Legislature.

Hon Mr Smitherman: Through the ministry, reporting to the House.

Mr Klees: Through the ministry.

With regard to the comments you made, you assured everyone that you have no intention as minister to interfere with existing contracts and agreements. Can you state for the record that there will in fact be an honouring of any and all agreements that exist now in Ontario that may have been entered into, either by hospitals or by boards, with service providers? Can you give us that absolute assurance?

Hon Mr Smitherman: Yes, I can, with one caveat, which is the one I went to some length to discuss in my speech, which is that there are provisions in the bill that

provide the ministry with the opportunity to seek accountability directly from CEOs after a process if we find that the board was not able to achieve that. But with respect to the reopening of collective agreements or contracts that have been signed between health service organizations and the like, that's not what this bill is about.

Mr Klees: So I'm assuming that perhaps one of the amendments you will be bringing forward is a withdrawal of subsection 40(3)(2.1), which reads: "Upon the advice of the general manager, and where the minister considers it to be in the public interest to do so, the minister may make an order amending a schedule of fees referred to ... in any manner the minister considers appropriate." So you're willing to put aside that clause that empowers you to interfere with existing schedules of fees.

Hon Mr Smitherman: What I can tell you is that we're going to provide you with what I called earlier a document that provides you with direction in terms of where we're going in various areas, and that is one that is significantly altered to make absolutely clear our intent. Our intent is that only in extraordinarily rare circumstances would those kinds of powers be used. I think you'll see that clearly from the focus of the amendments we intend to bring forward.

The Chair: Thank you, Mr Klees and Mr Wilson. Your time is up. We'll move on to the NDP.

Ms Shelley Martel (Nickel Belt): Thank you, Minister, for being here today. I want to deal first with hospital workers and their unions. I know Michael Hurley, who represents the Ontario Council of Hospital Unions, had a meeting on January 13 with the ministry—you might have been there; I think you were—and provided a written opinion of the bill that had been given to them by Sack Goldblatt Mitchell. There are two provisions I want to read, in which would explain why they came to you with the concerns that they did.

First, "The most potentially far-reaching and controversial provisions contained in Bill 8 are those contained in part III, sections 19 to 32, and relate to the ability of the minister to require persons to enter into accountability agreements or to issue compliance directives, set out in part III of the bill. In general, these provisions have been drafted in extremely broad and general terms and, as a result, grant the minister virtually unprecedented power to require individuals and organizations to comply with seemingly unfettered ministerial initiatives and orders in relation to the provision of health services, and potentially extending to the overriding of collective and other negotiated agreements."

Following that, this is the particular amendment that I want to ask you about: "More ominously, however, under section 26, where in the opinion of the minister, any person or organization fails to enter into or comply with any terms of the accountability agreement, or fails to comply with all or any part of a compliance directive, the minister may make an order providing for certain consequences which are, again, to be left to regulation. In other

words, the minister may make any order which regulations may permit. At this point, it is entirely unclear what the nature of these regulations will be and as a result what power the minister will have where a party refuses or fails to enter into an accountability agreement."

It's section 26 that provides you with the power to make an order that provides for any number of measures which we don't know because they're all going to be prescribed. Is it your intention to take that section out entirely? Is there going to be an amendment to that particular section? What are you doing specifically that would respond to the concerns that were raised with you?

Hon Mr Smitherman: I'm happy to tell you exactly what I told them at that time, and any other labour union leader who has spoken with me: This bill is not about unions and it's not about individuals; it's about organizations. I mentioned in my speech that what we're anticipating is independent health facilities, community care access centres, long-term-care facilities in Ontario's hospitals; and with respect to the language or nature of amendments that would fulfill that commitment, I would just refer back to the commitment I made to Mr Klees, the member from Oak Ridges, which is to provide within 48 or 72 hours to this committee a sense of where we're heading in terms of our areas of commitment to amendments.

Ms Martel: If I might, Minister, if you look at section 26, there's a reference back to sections 21 and 22. While I appreciate your saying that this is supposed to respond only to CCACs or organizations, it does say very clearly "a health resource provider." It would be hard for a health care worker not to assume they might be covered as a health resource provider. It also says "any other prescribed person," so that leaves it wide open.

Hon Mr Smitherman: What we've committed to do is make it absolutely explicit in the legislation whom we're talking about. I think that in reading from the legal opinion, you used the word "broad." We recognize that this is one of those areas where the bill will benefit from clarity, and we'll be very explicit about whom we're talking about in any of these instances. If there's any lack of clarity now, there will be absolutely no lack of clarity at the point that the amendments are brought forward and voted upon.

1350

Ms Martel: Just so I'm clear, because it was reported in the news that some proposed amendments were provided to the OHA and OMA—I'd be happy to get those. I'm going to assume that you're also going to provide us, within the next 48 or 72 hours, with the amendments that have been drafted to deal with the concerns of the hospital unions as well, not just the proposed amendments you gave to the OHA and the OMA.

Hon Mr Smitherman: No one has received any amendments yet. There has been some discussion around them and some exchange of language. But no one has walked away with a piece of paper that says, "This is the amendment intended here," because of what I said earlier, which is that some amendments affect both

parties and we want to make sure we get them right. So it's not factual to say that any amendments have been provided to anyone, nor is it factual to say that I committed to provide those amendments in the next 48 to 72 hours. What I said was that we'll provide you with a framework for where we're headed with respect to amendments and give you language around where we're going but not the actual language of the amendments. I think you will see from that the intended treatment for the sections you're speaking to—I shouldn't say "intended;" I would rather say "our recommendation," because this of course will be up to the committee.

Ms Martel: If I might, Minister: If you propose to have discussions, verbal or otherwise, with others with the full intention of making changes, you'll want to give the same courtesy to this committee as soon as possible as well.

Let me ask you about the role of the Ontario Health Quality Council. I heard you say, in response to Mr Klees, that was going to be one of the functions of the government's accountability in terms of what's happening in the health care system. It's not clear to me, though, as I look at their role in the bill, that they have a broad range to look at what's happening in the health care system or to make recommendations to you about changes. As I see the recommendations they are permitted to make, they have only to do with the schedule of what they're reporting on. Do they have, for example, power to look at a private CAT scan clinic to determine whether people are getting value for their money? Is that part of their role and mandate?

Hon Mr Smitherman: No, it is not. But we do support the extension of the powers of the Provincial Auditor to be able to provide advice to the Legislature of Ontario and the people of Ontario around value-for-money audits. It's our intention to have the Ontario Health Quality Council bring together a series of information that will provide Ontarians with a view about how their health care system is performing across a wide range of indicators. It's not our intention to turn that into a public policy-making body. We believe that is our role, but we do think it's critically important that a body made up of Ontarians provide information across a wide range of indicators about the performance of the health care system to all other Ontarians.

I think it's important to note as well that we really do think, toward our goal of making Ontarians the healthiest Canadians, it's critically important that we begin to capture more information about how we're performing as a society on key health indicators. Some of those I mentioned include rates of activity, smoking, obesity and the like.

Ms Martel: I appreciate the powers for the Provincial Auditor; however, I was referencing the powers of this particular council. You were the one who told Mr Klees that it was one of three mechanisms in the bill to ensure the ministry was accountable. I'm looking in the bill under the section with respect to the functions of this council and want to know, if the council comes forward

and decides you're not spending enough money on public health to deal with diabetes and smoking, where the accountability is for the minister to spend more.

Hon Mr Smitherman: I'm not looking for the Ontario Health Quality Council to play the role of determining where resources ought to be allocated. The fact of the matter is that a report they produce that indicates problem areas is of course going to have those pressures brought forward. That's the accountability that will be brought to bear on the government. This is not a body that we anticipate will be playing that role. It is a body that will be designed to bring together this broad range of indicators to report on the performance of the health care system and on the health of Ontarians.

Ms Martel: Then you can't really identify the council as a mechanism to make the government accountable with respect to the principles outlined in the bill: either accountability, accessibility etc. They've got a role that's pretty limited. We wish them well in their duties, but it's hard to describe that council as being a mechanism that's going to hold your government accountable when it comes to health care funding or ensuring any of the provisions that are outlined in the preamble.

Hon Mr Smitherman: I beg to differ. What would you call a report that comes out on an annual basis and highlights areas that need improvement? You've had the privilege of serving as a member of a government and in a government ministry, and I think you understand how the public reporting of information, not all good, is going to dramatically influence you and hold your feet to the fire in terms of a wide variety of performance indicators. I beg to differ. I think it's an incredibly powerful tool for Ontarians to have a glimpse, across a wide range of indicators, at the performance of their health care system. If you think that a minister of the crown, or a government, is not going to find that to be an accountability tool in terms of how they're doing, then you and I have a different take on accountability.

Ms Martel: We do. I look at their recommendations, and subsection 5(4) clearly says, "In a report under this section the council may make recommendations to the minister but only in regard to future areas of reporting." I don't see a mandate there for them to say to you, "We need more money in public health, and you should respond."

Hon Mr Smitherman: Yes, that's right.

Ms Martel: I don't see anything like that.

Hon Mr Smitherman: That's not our intended role. I'm not ducking this one; I'm telling you that this is exactly our intent, to give the capacity for Ontarians to have an at-a-glimpse view, on a wide variety of indicators, of the performance of their health care system.

I'll just give you an example. Recently I attended the 2003 version of hospital reports, based on year 2000-01. The media were very able, as a result of the information that was provided, to highlight areas in the health care system, and in hospitals in particular, where performance measures were not up to snuff and required effort. In the very same way, a report that takes a wider range of

indicators into play is going to highlight areas where the government has more work to do. That's inherent in it, and I think that's a very responsible position.

Ms Martel: Cancer Care Ontario talks about waiting lists all the time, but there still isn't a standard in Ontario with respect to adequate treatment times. Certainly there is any number of people who aren't getting that in a four-week period, as they would like in their own prescription.

Hon Mr Smitherman: I think you should stand by, because what you will have from our government is a very clear commitment around particular wait times. We're going to demonstrate to the people of Ontario over the course of the next four years that when the government of Ontario, working with a wide variety of health care partners, tackles a particular wait-time challenge, we can make demonstrable progress on it, and that demonstrable progress, set against the expectations we framed in the minds of the public, will be measured by the Ontario Health Quality Council. That's one further example of how that's an accountability tool.

The Chair: We're down to about the last two minutes, Ms Martel.

Ms Martel: I'm looking for the provisions in the bill that would ban for-profit private MRI clinics and make sure that CAT scans and that technology go into publicly funded, publicly administered hospitals. I don't know where that is.

Hon Mr Smitherman: If you want to ask me a specific question about a piece of the bill, I'd be happy to answer.

Ms Martel: Where are the provisions?

Hon Mr Smitherman: This is a commitment to the future of medicare.

Ms Martel: Where are the provisions?

Hon Mr Smitherman: As you know—

Ms Martel: Minister, it's a very simple question: Where are the provisions in the bill that ban for-profit private MRI clinics?

Hon Mr Smitherman: Regrettably, they don't exist. As you know, independent health facilities have been in existence in this province since 1990, I believe. There was even a modest expansion of for-profit, independent health facilities during the day of your government. I think that's the answer: There is legislation that governs independent health facilities.

Ms Martel: It's regrettable that they don't exist. It's regrettable that your government promised it would ban these before the election campaign and they are still operating. This is a bill that is supposed to recognize that medicare, our system of publicly funded health care services, reflects our values. I think many people told Romanow they wanted to ensure that public money went into publicly funded, publicly administered health care services.

It's a simple question: When are you going to live up to your commitment that was made during the election campaign to ban these clinics?

Hon Mr Smitherman: I read many pages of the Romanow report and didn't see in there where Roy

Romanow proposed the nationalization of every service in health care that is being delivered in a for-profit way.

Ms Martel: He did make it very clear there was no evidence to support that the private sector could provide these services more effectively. He made that very clear, Minister.

The Chair: Thank you, Ms Martel. Your time has expired.

Questions from the government side.

Mr Jim Brownell (Stormont-Dundas-Charlottenburgh): During the past week or week and a half, I've had many constituents approach me, especially those working in health care and hospitals, concerning the bill. MPP Wilson commented that the public is very interested in this bill, and they are. I've had many health care providers comment that they're afraid of losing jobs—we've had comments with regard to collective agreements and whatnot. Will this bill cause job losses in hospitals?

Hon Mr Smitherman: No. That's not what this bill is about, but it's what some people have attempted to make it about. What I have said in response to that is that we're going to make it abundantly clear and explicit in the bill that there's nothing in the bill that gives anyone the far-reaching powers to open collective agreements, as an example.

I read the media too, and I've seen how some people have been involved in that kind of a campaign in your community and in others across Ontario.

1400

Ms Wynne: I've had a question about section 10 in the bill come to me already. That's the section that lays out the associations that the Minister of Health and Long-Term Care can enter into agreements with. There are three, I guess. Are you looking at adding others?

Hon Mr Smitherman: What we're looking to do in that section—and this will be noted in the document that we provide—is to make it explicit which organizations we would intend to do that. Those are the four I mentioned earlier: hospitals, long-term-care facilities, community care action centres and independent health facilities.

Ms Wynne: This is a section that lays out the OMA, the ODA and the Ontario Association of Optometrists. Are there other associations that you're considering adding in that group? I've been approached by the chiropractors, but I don't know if they're—it's page 7, section 10.

Hon Mr Smitherman: Maybe you could stand that question aside for when ministry staff are up here and ask them. They'll give you the rationale for why that's in there.

Ms Wynne: OK.

Hon Mr Smitherman: The short answer is no, but they'll give you a more detailed rationale for it.

Ms Wynne: OK. I'll get an explanation. Thank you.

The Chair: Mr Duguid.

Mr Brad Duguid (Scarborough Centre): I want to begin by suggesting that I'm very pleased by the approach that the minister is taking on this particular piece

of legislation. I know from previous experience how governments sometimes will be entrenched when they come forward with a piece of legislation, rather than listening to concerns as we move forward. I want to thank the minister for the approach he's taken to date, the responsibility he's taking on himself to make improvements and to work with this committee to make improvements. I think that's a breath of fresh air for the process and for the system.

My question is on the health council itself.

Interjection.

Mr Duguid: What's that?

The Chair: You have the floor, Mr Duguid. I think we all heard it. We don't need it repeated.

Mr Duguid: I've got a concern that the health council could become just a committee of special interests or a committee of people with preordained agendas. I'd be interested to know what your thinking is in terms of the appointments to this committee and who will be included or precluded from sitting on this particular body.

Hon Mr Smitherman: Just off the top, you pay me a compliment, but the fact of the matter is that the first draft of the bill that was introduced in the House didn't get it right, and I take responsibility for that. So the approach is necessary, frankly, because the bill needed help, and the committee's going to be very helpful.

One of the issues that I think you're going to hear about—and I noticed this when we sought appointees to the national health council—is that a lot of appointees in health have historically come out of stakeholder groups where someone would say, "If it's 12, you need a nurse and a doc and someone from the labs," and they just take the pie and look at the big 12 players and line those up. I don't mean to diminish any of those groups in any way. They're obviously critically important. In the Ministry of Health, I can assure you there are more stakeholders than you can imagine, because the pie is very large and each medical service in its own right is very distinct.

We believe that across this amazingly large province and the 12 million people who inhabit it, we've got the opportunity to bring together people who come from communities and have a very broad-based knowledge about the health care system. In explicitly limiting people who are wearing a stakeholder hat from being appointed to the council, I feel that it helps to make the point very clearly that this needs to be about broad-based experience and about understanding that the people who are on the council are really there voting, if you will, in the interests of the 12 million Ontarians who are our core stakeholders. So I think you're going to get some pushback on that, but that's a provision I feel incredibly strong about.

Mr Duguid: One more question, Mr Chair: Our sports teams in this city contribute greatly to both our economic and social well-being as a community, in Toronto and across Ontario—our sports teams across Ontario. Eddie Belfour's back ailment may not be an important public issue for the province of Ontario, but it certainly is to the people of Toronto, heading into the playoffs. I want to get your assurance that this legislation will not in any

way impact the ability of sports teams to have their athletes treated in an appropriate manner so they're not going to be left at a competitive disadvantage with other sports franchises across North America.

Hon Mr Smitherman: I'm going to answer your question in a very different way. I'm a big Toronto Maple Leafs fan. I declare my interest as the local MPP for both the Air Canada Centre and Maple Leaf Gardens, but at the end of the day, my responsibility, our responsibility, is not to worry so much about Ed Belfour's back as about Mrs Smith. At the end of the day, what we have in Ontario is regulations put in place during the time of the New Democratic Party that ensure that no uninsured party would ever be able to access a service and queue-jump over an Ontarian who's in the same lineup. So under this bill and under the status quo in Ontario, Mrs Smith is never going to lose her spot in line to a professional athlete.

Mr Bob Delaney (Mississauga West): Minister, I worry terribly about Mrs Smith. She has been sick for so long with so many different things, she may become one of the parameters by which we measure.

I'd like to ask you a few questions about the Ontario Health Quality Council. Let me know if I'm going a little bit too deep into the minutiae of its operation as compared to where you are in the development of it right now. How do you envision the health quality council gathering, validating and processing data?

Hon Mr Smitherman: I think that one of the things the health quality council will have the advantage of being able to do is build on a lot of the data that is already out there and bring it together in one place. Every single day, it seems, there's a new report that comes out about this or that in health, not necessarily measured against the same research parameters, as an example.

In our discussions last week with the Ontario Hospital Association—in one of the more forward-looking initiatives in partnership between government and the Ontario Hospital Association that I think traces its roots to your government, hospital reports have become quite standardized in the province of Ontario. We're a partner in those. The ministry and the government of Ontario, partners in that, pay for a significant amount of it. Some of that reporting and some of the other reporting we do—for example, Ms Martel referred to Cancer Care Ontario. We would bring together some of the existing data in one place and then look for those gaps across that broad array of health indicators to determine where more research is required and to help to frame how that research and information would be conveyed to the public. But a lot of that work is certainly yet to be done.

Mr Delaney: Would the act of gathering the data under the auspices of the health quality council serve to assist hospitals in ensuring that the data they gather can be effectively compared on an apples-versus-apples basis, on a common basis?

Hon Mr Smitherman: I think one of the primary benefits is that there would become, if you will, a standardization of the research methods we utilize in

collecting that kind of information. Right now, the fact of the matter is that it comes at you fast and furious from a variety of different directions, and it's very, very difficult to determine sometimes whether one study on a subject is more valid than another. There's a lot of research in health, and keeping track of the information, not least of all for me but especially for Ontarians who are, after all, inundated with a variety of information coming from so many different directions—I think would be very helpful in that regard.

1410

Mr Delaney: We've talked a bit about the constituent members of the health quality council. What type of activity does the ministry anticipate that the members of the health quality council will do? For example, how often and where will they meet?

Hon Mr Smitherman: We anticipate that they would meet on a regular basis, probably monthly. It's critically important that groups acting on behalf of Ontario get a chance to see all of Ontario. I'm one of those who are delighted, perhaps because I'm not going, that committees are travelling. I certainly enjoyed my visit to Terrace Bay three weekends ago when it was about minus 45, and I ended up in North Bay. That's an important part of it.

What we would expect is early leadership from that group to take a look at some of the work the National Health Council is doing, to determine efforts that can be made at the Ontario Health Quality Council that are complementary to the work of the National Health Council, and to determine the appropriate way to do research so we can report to Ontarians on an apples-to-apples comparison, to use the phrase you used.

Mr Delaney: What nature of staff, consulting or administrative support does the ministry anticipate the health quality council will need?

Hon Mr Smitherman: We haven't gotten down to detailed budgeting on those things. The ministry can be a very significant resource in helping to establish it and get it running, but further to that we haven't taken a look at what an annual budget would look like.

Mr Delaney: Will the same set of parameters or key indicators be measured every year? What will establish the council's priorities?

Hon Mr Smitherman: That's actually something the council has to provide leadership around. It's obvious and critically important, if you go back to one of my earlier answers, that we make sure the government has an opportunity to be held accountable to particular targets it's going to establish. So the annualized measurement and reporting on a consistent number of indicators is, of course, critical to track our progress or frankly, and perhaps more particularly, to indicate if we've slipped on any indicator. If we're going to track the rate of smoking among 15- to 18-year-old girls in one year, and the government is working on an initiative on smoking cessation in that same group, we obviously need to know what the numbers tell us about how we're doing.

Mr Delaney: Will there be any means to evaluate the contribution of the council's members and to make changes if a member either cannot or will not contribute?

Hon Mr Smitherman: There are always opportunities to do those sorts of things through order in council and the like; so, yes, but only as required.

The Chair: Ms Wynne.

Ms Wynne: I've already gotten calls about the recommendations section, and I think it's going to come up as we travel, so I just want to be clear that this report that comes out each year will be a report card and there will be standards against which the performance will be measured. Is that an accurate description?

Interjection.

Ms Wynne: I'm not wasting time. I actually do want to know this, because it's going to come up.

Hon Mr Smitherman: The issue of standards is critical. Standards are in a sense a marker we lay down and say they're not just our goal, but that objectives are in place to achieve those.

The only cautionary piece I would have about that, and it's something I think anyone who's served in government would have, is that in the Ministry of Health it's very easy to succumb to the idea that you can do everything as a one-off. The pressure comes intensely from every corner on every day to do this and that. I think a good expression is: If you have 100 priorities you have none.

We, as a government, plan to lay down markers on particular wait-time challenges and aggressively chase progress in those areas. We expect that the Ontario Health Quality Council will be critically important to report to Ontarians on how we're doing against the markers we lay down.

Ms Wynne: Do you see this bill as a mechanism to promote wellness in the province?

Hon Mr Smitherman: Absolutely.

Ms Wynne: I think that was one of our fundamentals in our campaign. Can you talk about that?

Hon Mr Smitherman: I mentioned in my opening remarks that it isn't just about system performance; it's about system performance, health outcomes and measures around the health of Ontarians. It's our government's commitment to make Ontarians the healthiest Canadians. That means we obviously need to make progress on items like the rate of physical activity amongst all age groups, smoking, obesity and the like. I think you could all imagine a day, two and three years after the first report, when people are going to take a very keen interest in the percentage of Ontarians who are smoking or the percentage of Ontarians who are active. I think those indicators are going to be critically important. The fact of the matter is, if you look at some of the challenges we're facing in health care, that many of the most significant challenges we face are about trying to find the resources to address disease that is preventable. At the end of the day, marrying these two things together is critically important to achieving our goal and, frankly, critically

important if we're going to be able to make health care sustainable from a financial standpoint.

The Chair: Thank you, Mr Minister. It's a quarter after two. The time for your presentation is expired. We appreciate your being here.

Hon Mr Smitherman: It's my pleasure.

The Chair: We're going to return now to the official opposition.

We'll be sitting until 3 o'clock, so we'll divide the time accordingly, which will be about 17 to 18 minutes for the Liberals and 10 minutes for the NDP.

Mr Peter Kormos (Niagara Centre): Ten or 11.

The Chair: Ten or 11.

Mr Klees, are you going to start off?

Mr Klees: Yes, Chair. I'd like to return to the issue of accountability. On one hand, I was encouraged by what the minister had to say about the fact that there will be many amendments to this bill. I must admit some frustration, however, because in one sense this committee is taking this bill in its current form on the road to communities across the province. I'm concerned that we're taking a bill for consultation that in reality bears no resemblance to what the minister ultimately has in mind. We've already heard there are many amendments, which I suppose we'll have in some form—not specifically but no doubt some vague reference—by the time we get whatever is presented to this committee. The very foundation, the very intent of this legislation that's being proposed is apparently now no longer. This minister has gone into retreat; he's folded his tent. He's abandoned the very principle that initially was being driven by this government, which was that he was going to take away from local boards, CEOs and foundations, if you will, all their authority and assume that authority in the minister's office. Time and time again we reference in this bill where the minister will have the ultimate authority to make decisions. What we're taking on the road, I don't know.

I would like to direct to the parliamentary assistant, who no doubt is familiar with the details of this bill, that clause 27(1)(a) makes reference to one of these instances. The change it's referring to is a material change in terms of employment etc. This clause reads: "The change shall be deemed to have been mutually agreed upon between the person and his or her employer." The same language is used again in clause 28(a): "...shall be deemed to have been mutually agreed upon by the parties." This is about as archaic language as I have ever read in any piece of legislation. I want to ask the parliamentary assistant, given the minister's assurance to this committee that he is retreating from the intent of having the minister effectively take over hospitals, take over boards, take over the making of contracts or remaking of contracts, if this wording will in fact be removed from this act and, if not, what exactly do you have in mind? Why is it necessary to have this language in this act?

1420

Ms Monique Smith (Nipissing): I can appreciate your concerns about changes to the legislation; however, I think your hyperbole today is a little outlandish. I don't

think that in any way has the minister indicated today that he is retreating from the intent of this legislation. I believe he indicated that he felt the tone that was set by the original legislation was not appropriate, that he has taken responsibility for that, and that we are looking at different ways to change the tone. However, I don't think in any way did he indicate in his statement today that he was changing the intent of the legislation. I don't think that he indicated in any way he was folding his tent, abandoning his principles or any of the other statements that you made, which I believe were somewhat irresponsible.

I think that what you'll see in the next 48 hours to 72 hours is a framework for some of the changes that have been discussed with some of the stakeholder groups, although I think it's important to remember that we've not spoken with all stakeholder groups. We have, I believe, six or seven days of hearings ahead of us where many stakeholder groups will be coming to make presentations. We are anxious to hear their concerns and their issues. I'm sure you, as well as the rest of the members of this committee, are anticipating taking those views forward and looking at appropriate amendments to this legislation.

Mr Klees: Chair, is the parliamentary assistant going to answer my question or not? It was very specific with regard to the wording in sections 27 and 28 are concerned. I'm waiting for an answer.

Ms Smith: I believe the minister already indicated that he would be providing us with a framework of changes to the legislation, but not actual specific language amendments. As far as sections 27 and 28, I can't give you that assurance at this time.

Mr Klees: Has the parliamentary assistant seen any of those proposed changes?

Ms Smith: I have been privy to some of the discussions around some of the changes, but I have not seen final language on any changes.

Mr Klees: Can the parliamentary assistant tell me why in the preamble there is very specific reference to pharmacare being an important principle—"pharmacare for catastrophic drug costs"—and yet there is no reference whatsoever in this bill to pharmacare?

Ms Smith: I think you'll see that in the preamble there are references to pharmacare for catastrophic drugs, to home care and to consumer-centred health systems. We refer to a lot of things in the preamble which are value statements as to what we believe is protected in medicare, and which values will be sustained and protected through the implementation of this act.

Mr Klees: So it's your intention to bring some amendments forward that specifically reference pharmacare and its importance to health care in Ontario?

Ms Smith: Again, Mr Klees, you can keep asking as many times as you want for what will be specifically brought forward in amendments, and I will keep giving you the same answer.

Mr Klees: My, we're chippy. Very interesting. You're certainly setting a tone for this committee. It's your first committee, is it?

Ms Smith: I apologize, Mr Klees, if you're taking exception to my tone. It's certainly not intended to set a tone for this committee. You've asked me the same questions three times now, and I've given you the same answer.

Mr Klees: Well, actually, no. It was twice, and I thought that perhaps you didn't understand my question. It is our intention in these committees to try to work through the details of legislation. It's really not intended to be a debate. Hopefully we're working as a committee to improve and develop a piece of legislation that indeed reflects the intent. That's what the work of this committee is all about. I do hope that we can get to that tone, if you will, as we move forward.

I'll defer to my colleague.

Mr Wilson: Mr Chair, perhaps to the parliamentary assistant: I'm just a little confused. If you've got a problem with the Canada Health Act, shouldn't you be dealing with this at the federal level with your federal cousins? Clearly this bill says, "We don't like the Canada Health Act. We don't think it guarantees accessibility. The penalties in there aren't strong enough."

What is your problem with the Canada Health Act? Why don't you come clean with the people of Ontario and Canada and say why you don't like the Canada Health Act and why you need this legislation? If you don't have a problem with the Canada Health Act, then this legislation is bogus. It's just picking a fight with Ontario's doctors, an unnecessary fight with volunteer boards and an unnecessary fight with administration at hospitals. So somebody tell me over there why you're doing this legislation, what is your problem with accessibility and why you can't do the whole country a favour, I guess, and suggest what amendments should be made to the Canada Health Act, if indeed you don't like it.

The Chair: Ms Smith, would you like to—

Ms Smith: I don't believe this bill reflects that we have a problem with the Canada Health Act. We're in fact emphasizing the importance of medicare in this province, we're ensuring accountability and we're ensuring accessibility. That's the statement behind this legislation. That's what we're reinforcing. It in no way is attacking the Canada Health Act.

Mr Wilson: It's not just having a press conference and talking about motherhood. You're actually bringing in legislation. You're going to ask this Parliament to vote on it. You must have a problem with the Canada Health Act, because you're defining "accessibility" and your protections around accessibility in your own image. You're doing it unilaterally, as far as I know. I was the chairman of Canada's health ministers for two years. You're doing it unilaterally. I don't have any other health ministers telling me anything right now except that Ontario is off playing motherhood. Well, you're either wasting our time or you've got a problem with the Canada Health Act. So what's the problem with the Canada Health Act?

Ms Smith: I think—

Mr Wilson: By the way, you campaigned on this crap. You went around saying we were violating the

Canada Health Act. Tell me how we violated the Canada Health Act and what your problem is with it.

The Chair: Mr Wilson, are you going to let that statement stand?

Mr Wilson: Yes.

The Chair: Very good.

Mr Kormos: The Chair can't do anything about it.

Mr Wilson: I've been here 14 years; I can bloody well say "crap" if I want to. Don't do me any favours, Peter.

Ms Wynne: Can I just add something?

Mr Klees: Mr Chair—

The Chair: Mr Klees, would you stand down. Mr Klees said we were trying to set a tone here and perhaps he'd be offended by some of the questions and answers.

Mr Wilson: I'm trying to find out the problems with the Canada Health Act.

The Chair: It's the first day of hearings—

Mr Wilson: I don't like driving down here for three hours to find a bunch of bogus crap. What is wrong with the Canada Health Act and why are you seeking to unilaterally, without any other provinces, change the definition of accessibility?

The Chair: Are you finished, Mr Wilson?

Mr Wilson: Yes.

The Chair: Thank you. It's the first day of hearings. I would like to set a tone here. I would like to see a tone set. I think some of the questions that have been asked have been wonderful. Some of the answers that have been given may not have been the answers people wanted to hear, but I think people were trying as hard as they could to give them. I would like to see that tone either continue, at least at that level, or improve, hopefully, as we move through the hearings. If I can return to you, Mr Wilson.

Mr Wilson: My question does stand. Surely to God you had some reason to criticize us, to criticize everybody else who is trying to follow the Canada Health Act. What's your problem with it?

The Chair: That question has been asked and answered.

Ms Wynne: Could I just add something? I had actually asked the question a week ago, in preparation for these hearings, whether Ontario was the first provincial jurisdiction in Canada to establish a health quality council. In fact, we're not. Alberta, Saskatchewan and Quebec also have similar bodies. They're not identical, but they do have similar bodies.

Going back to what Ms Smith said, this is not about contravening or contradicting or having a problem with the Canada Health Act. This is about affirming and establishing those principles in Ontario. I think you could look at those other bodies in those other provinces and understand that we're not the first.

Mr Wilson: I know. I'm quite familiar with BC's example and their Liberal government.

Ms Wynne: BC is not one of the ones—

Mr Wilson: Maybe I can be clearer: You have a problem with accessibility. That's what you say in your

preamble, that's what you say in your press release, that's what you say in your backgrounder. You have a problem, obviously, with the legal protections around accessibility and queue-jumping. You're setting up a council to—I don't know if it's going to have real teeth or not. My colleague's right; we won't know whether it's going to have any real teeth until we see amendments.

It says to me that you've got a problem with the Canada Health Act, which is sacrosanct. I've heard your leader say it's sacrosanct and he loves it. But clearly, there must be a problem you're trying to fix here. Why you're not doing it through the act that actually has teeth and can be enforced with clawback payments to the provinces and all those protections, I don't know. So I'm asking, why are you doing it at this level when it's likely to fail and not have much effect?

The Chair: That question has been asked a few times. You have about three minutes left. Would you prefer an answer, or would you prefer a new question?

Mr Klees: I have a sense we won't get an answer to that so I'd prefer to make another comment with the time we have remaining. It's a follow-up on what my colleague has been referring to, and that's the issue of the public interest.

What I find lacking is, there is no reference, throughout the entire bill, to the public interest. There is reference to the minister's rights to make decisions, to appoint, to render existing contracts void, to replace fees, to eliminate fee schedules; there is reference to the appointment of this council chair; but there is nothing in the entire bill that clearly instructs that this council must act in the public interest.

1430

We're in the process of developing legislation here. Why is this important? We have had some experience in this province with an organization—the Health Services Restructuring Commission, for example—that was mandated to go into the province, assess health care within regions and then make recommendations. As a result of that, serious restructuring took place.

But what was very clear in the mandate that was set out for that commission was that it must be in the public interest. What this bill leaves open is that at the whim of the minister, the whim or inspiration of the Ministry of Health and its sundry staff, initiatives are taken within a particular community that may very well not be in the public interest. So I put forward to this committee that surely as amendments are considered by the Ministry of Health—as this committee considers this legislation and the far-reaching implications to health care—we should incorporate the principle of “in the public interest” so that we do not leave that vacuum. The implications could be very, very significant.

The Chair: Thank you, Mr Klees. Good timing.

Mr Kormos, you have 11 minutes.

Mr Kormos: Thank you kindly. I want the Chair to know that I've noted the tone of bitterness, of rancour—*Interjections.*

Mr Kormos: Well, I feel I have a right to participate in this committee without fear of the intimidating climate

that's being generated by other committee members. I quite frankly expect this Chair to protect my right to be able to participate in this committee without fear and without feeling that there's a hostile environment that I've been thrust into. I have a right to that.

I read the proposition regarding accountability. Down where I come from, in the health care system the hospitals are the largest single spender of public tax dollars in our community. If you're talking about accountability, why hasn't the ministry addressed the most fundamental element of accountability; that is, hospital governance and the fact that hospital boards are still chosen among a small group—a clique, inevitably—of backroomers with no public accountability? It seems to me that the most fundamental address of the issue of accountability would be to overhaul hospital governance so that, at the very least, municipal hospitals like the ones where I come from and where more than a few other members come from have publicly elected hospital boards with accountability to the taxpayers—to wit, voters—who fund those hospitals, who pay the high-priced, six-digit salaries to the fat and unaccountable CEOs. This isn't a hostile question, but why hasn't that fundamental issue of governance and the accountability of hospital boards been addressed by way of creating publicly elected hospital boards?

Ms Smith: This legislation does not deal with governance; it deals with accountability. It's the view of this government that the accountability should be between the hospital and the ministry. Hospitals have determined their own governance. We are dealing with accountability. I think it's a different issue.

Mr Kormos: I appreciate the response, but I say to you that accountability fundamentally, then, means accountability to the people of the province. The minister himself spoke of 12 million Ontarians.

Perhaps I could address this to bureaucrats from the ministry: What is the status of consideration of an overhaul of fundamental hospital governance? What's the status of that within the ministry?

The Chair: Could you identify yourself for Hansard before you begin.

Mr George Zegarac: I'm George Zegarac, the ADM for the integrated policy and planning division.

That is a political question. That really is a political direction issue. We constantly work with the joint provincial planning committee of the hospital association and look at how we can improve on the accountability measures, but we're not engaging, certainly at the bureaucratic level, in discussions around reformulating governance structures.

Mr Kormos: Fair enough, and I don't dispute, obviously, that response at all. But has there been consideration of alternative models of governance by the bureaucracy, by the civil service, in terms of the sort of work that they do in terms of developing alternative policy and options for ministers and political personnel?

Mr Zegarac: Have there been discussions over the years? There have been discussions over the years around

different governance structures, not specifically to hospitals.

Mr Kormos: OK. Have there been discussions about the direct election of hospital boards to make them truly democratic and accountable?

Mr Zegarac: Not that I'm personally aware of.

Mr Kormos: I understand "you're aware of." Come on, let's not make this sound like something out of the 1950s. I appreciate you may not personally be aware of them. Have those considerations been undertaken by bureaucracy, by civil service, insofar as you know, without being personally familiar with the actual considerations?

Mr Zegarac: I honestly can't say how much detail has gone into governance structure discussions around hospitals or others. I know in the previous government we dealt with CCACs. We have not dealt with hospital restructuring, certainly, as a policy platform.

Mr Kormos: What would it take to get the bureaucracy to understand that the direct election of hospital boards is the one fundamental way of creating true accountability?

Mr Zegarac: I think bureaucracy looks at all of the options and provides the best advice we can to our political masters, and that direction comes from our politicians.

Mr Kormos: I recall—gosh, I look across, and other than those who would have watched it on television, none of you were here at the time, but I recall a similar fiasco in which a former Minister of Finance, one Ms Ecker, found herself. My colleagues over here will know whereof I speak. Ms Ecker presented legislation to the chamber and was steadfast, to her great credit, in insisting that particular sections did not have the horrendous and horrible impact that opposition members, Liberal and New Democrat—the Liberals followed our lead on that—insisted that it would. Notwithstanding that, when the legislation passed, she declined to have them proclaimed. Again, you weren't here; you don't recall that. You see, that's the problem. We lose institutional memory when there are these huge schisms.

Let me ask the parliamentary assistant or the bureaucracy who's here—you're not alone.

Mr Zegarac: No, I'm not.

Mr Kormos: You've got folks here with you, right? They didn't send you here alone. The annual income in here is over a million bucks a year, I bet, right now. So either the bureaucracy—

Interjection.

Mr Kormos: Well, I'm talking about politicians as well, right? Don't worry. Between the political people and the bureaucracy people.

Just where in section 27, when you read it—and I just read the plain language stuff; I don't profess to have any great talents or skills, and my critics will reinforce that observation. But when you talk about "the change shall be deemed to have been mutually agreed upon between the person and his or her employer"—"employer" implies boss and "person" in that relationship implies

"worker." So when a minister makes an order under section 26, there's a material change, including a reduction of the compensation payable—that could mean wages, right? So why should a CUPE member or an SEIU member not read that like I have, in my simple, modest way, and say, "Lord thundering, the way I read it, the law says that if the minister makes an order which includes a reduction in my pay, I shall be deemed to have agreed to that. I can't even protest"? What's the flaw in that observation by an SEIU member or a CUPE member? A person, an employer, a worker, a boss, a reduction in pay—I've been through this before. You remember that? Were you around here in the early 1990s?

1440

Mr Zegarac: I was. Let me address your question. First of all, I think the minister made it clear that this provision does not deal with employees and never has. So this provision will have explicit wording to make it clear that what we're looking at here is, quite frankly, the CEO, or chief executive officer, who would have an agreement with the board, and that board's agreement would basically reflect the agreement that it has with the ministry or with the minister. So this provision in no way has any impact on employee salaries of any institution other than a CEO.

Mr Kormos: I understand when you explain what the intent is, but do you understand what I'm saying? What about the language of that? Where did I err in drawing the conclusion that it could apply to a worker? Workers are persons, and "employer" means bosses. Where did I err, notwithstanding the assurance of the minister and yours, in saying, "Yikes, this could well apply to a worker who belongs to a collective bargaining unit"?

Mr Zegarac: I think the minister was quite upfront talking about the issue of clarity and that he has instructed that some of the issues we normally would have dealt with in regulations be addressed in the legislation directly. So I think you will see in the amendments that are proposed—wording or framework—that will be addressed.

Mr Kormos: How did this slip through the vetting process?

Mr Zegarac: I don't think it's slipping through. I think it's an issue of looking at wording that would be explicit, and some of that explicit wording often comes in regulation. We're making a commitment to put that in legislation.

Mr Kormos: This wording is vague, right? That's what you're saying?

Mr Zegarac: The wording could be more explicit, and that's what we're hearing.

Mr Kormos: To wit, it's vague. Therefore, it should be more explicit?

Mr Zegarac: The question is whether that explicit wording goes in regulation or in legislation.

Mr Kormos: But what are you going to do: define words like "person" in regulation? Was that your anticipation? Was that your contemplation?

Mr Zegarac: We will define who is subject to that provision, yes.

Mr Kormos: How did this slip through, though?

Mr Zegarac: If I may, I'll introduce Laurel Montrose, who's our legal staff.

Mr Kormos: You didn't draft this, did you?

Ms Laurel Montrose: No, not personally, but I have worked on this bill.

Mr Kormos: Who did?

Ms Montrose: The office of legislative counsel drafts statutes. We just work on them.

There is a definition of "health resource provider," and when it gets to the level of a person, who would be an individual, it applies only to the CEO. I think that's a little earlier in part III.

The thing about a law, Mr Kormos, is that you have to read the whole thing; you can't just take out one section or subsection. If you read the whole thing together, I think you might find that it applies only to CEOs as individuals.

Mr Kormos: I'll send a letter to Sack Goldblatt Mitchell this afternoon admonishing them for the conclusions they reached. They probably charged a whole whack of dough for that legal opinion. I'm ashamed of Sack Goldblatt for not having read the whole bill. Is that what you're suggesting?

Ms Montrose: No, I was just suggesting that you can't read a bill in isolation. If you looked back at the earlier subsection, you would find that it's confined to CEOs.

Mr Kormos: But the minister is going to amend this section, isn't he?

Ms Montrose: Mr Kormos, you were speaking to the current bill, and I was just answering your question.

Mr Kormos: The minister is going to amend section 27, isn't he?

Ms Montrose: I can't speak to the minister's intentions.

Mr Kormos: He apparently outlined the proposed amendments to—what is it?—OMA and OHA a couple of days ago, according to one Ian Urquhart. I don't know. Can I believe Ian Urquhart when he writes that stuff?

Ms Montrose: I can't answer those questions. I'm sorry.

Mr Kormos: Can you?

Mr Zegarac: I think the minister has made it clear that he will, in the next 48 hours, share wording, or framework around wording, that we have engaged in discussions on with a number of stakeholders. But we have to take into account that there are competing wording interests and discussions that are continuing to occur both at this committee level and outside with stakeholders.

Mr Kormos: Clearly, at some point, somebody in the ministry decided we're going to back off on this. We're not going to stonewall any more. The minister's going to respond by saying there will be amendments, right? That was the decision that was made in the ministry?

Mr Zegarac: No, I think the discussion we've had here is that there was discussion around clarity and that we have engaged in a discussion around making this more clear.

The Chair: Thank you. That's 12 minutes. Thank you, Mr Kormos.

Mr Kormos: Is that 12?

The Chair: It was actually 12 and a half.

Mr Kormos: My count was 10.

The Chair: It was 12 and half, on the dot.

Ms Smith: I was just going to respond to Mr Kormos, but I believe that our representatives from the ministry have done that.

The Chair: Very good. Are there any further questions of the ministry staff from the Liberal side?

Mr Kormos: On a point of order, Mr Chair: I wonder if legislative research could determine for this committee how much health care—to wit, nursing care, amongst other things—the hundreds of millions of dollars the Liberals stole from taxpayers in Ottawa could have provided Ontarians.

The Chair: Thank you, Mr Kormos.

Mr Kormos: Thank you. I look forward to the—

The Chair: Yes, that was a wonderful point of order.

Are there any questions from the government side on the legislation?

Ms Zegarac: Maybe, while I have Laurel Montrose here, we can actually respond to the earlier question around section 10. Laurel, I'll ask you to speak to that.

Ms Montrose: Just as a matter of context, part II of the bill, which is the health services accessibility part, is really essentially a cut-and-paste of the existing Health Care Accessibility Act. We simply drafted it this way so it would be easier to follow. Section 10 of part II is essentially a cut-and-paste of the existing Health Care Accessibility Act which was enacted in 1986. There's been no change, so the three organizations listed in section 10 were the three listed in 1986. As a matter of law, this particular provision allows the minister to enter into agreements with these organizations, but as a matter of law, the minister does not require statutory authority to be able to enter into agreements with organizations. So this is an empowering provision, but it in no way limits the minister's authority to enter into agreements with organizations that aren't listed in the section.

Ms Wynne: So in fact if an organization like the chiropractors wanted to enter into an agreement, there's nothing here that would prohibit that.

Ms Montrose: Absolutely.

Ms Wynne: OK.

The Chair: Thank you. Are there any further questions? There being none, is it the committee's pleasure that we adjourn to Sudbury? Hearing no opposition—

Interjection: Do we have a choice?

The Chair: Do they have a choice? No.

For those who are travelling by plane to Sudbury, the cars will be at the south door at 4:30. I just wonder if I could ask the members of the subcommittee if they would maybe stick around for a minute at the end. Thank you. We're adjourned to Sudbury.

The committee adjourned at 1448.

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Ms Monique Smith (Nipissing L)

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Mr George Zegarac, assistant deputy minister, integrated policy and planning division

Ms Laurel Montrose, legal counsel

Clerk / Greffière

Ms Susan Sourial



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First Session, 38th Parliament

**Official Report
of Debates
(Hansard)**

Tuesday 17 February 2004

**Standing committee on
justice and social policy**

Commitment to the Future
of Medicare Act, 2003

**Assemblée législative
de l'Ontario**

Première session, 38^e législature

**Journal
des débats
(Hansard)**

Mardi 17 février 2004

**Comité permanent de la
justice et des affaires sociales**

Loi de 2003 sur l'engagement
d'assurer l'avenir
de l'assurance-santé



Chair: Kevin Daniel Flynn
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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON
JUSTICE AND SOCIAL POLICY

Tuesday 17 February 2004

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

COMITÉ PERMANENT DE LA JUSTICE
ET DES AFFAIRES SOCIALES

Mardi 17 février 2004

The committee met at 0833 in the Howard Johnson Plaza Hotel, Sudbury.

COMMITMENT TO THE FUTURE
OF MEDICARE ACT, 2003LOI DE 2003 SUR L'ENGAGEMENT
D'ASSURER L'AVENIR
DE L'ASSURANCE-SANTÉ

Consideration of Bill 8, An Act to establish the Ontario Health Quality Council, to enact new legislation concerning health service accessibility and repeal the Health Care Accessibility Act, to provide for accountability in the health service sector, and to amend the Health Insurance Act / Projet de loi 8, Loi créant le Conseil ontarien de la qualité des services de santé, édictant une nouvelle loi relative à l'accessibilité aux services de santé et abrogeant la Loi sur l'accessibilité aux services de santé, prévoyant l'imputabilité du secteur des services de santé et modifiant la Loi sur l'assurance-santé.

The Chair (Mr Kevin Daniel Flynn): If you would take your seats, we can call the committee to order for the morning. I'm sure some of the members will be joining us in progress.

ONTARIO PUBLIC SERVICE EMPLOYEES
UNION, LOCAL 659

The Chair: Our first delegation this morning is from the Ontario Public Service Employees Union, Local 659, Sudbury Regional Hospital, Yves Shank and Jan O'Leary. You have 30 minutes for your presentation. Any unused time from the presentation will be used by members of the three parties to ask you questions or perhaps for any clarifications. The floor is yours.

Ms Jan O'Leary: We'd like to thank you this morning for this opportunity to speak to you about some of our concerns with Bill 8 in the format introduced by the newly elected Liberal government last November. My name is Jan O'Leary, and this is Yves Shank. We appreciate the ability to discuss this matter in a public forum in the hopes of contributing ideas that will help redefine this bill into a commitment for the future of medicare that we can all support and believe.

We represent approximately 314 hospital professionals in the Sudbury Regional Hospital system. We

also represent OPSEU hospital professionals working in our hospitals in our capacity as executive members of the hospital professionals division. We are both laboratory technologists. I have proudly worked in the hospital system for over 29 years, and Yves has done the same for 13 years. We have been active proponents supporting public health care for the length of our careers. I have vigorously fought against the privatization of laboratories, supported by strong evidence that private labs cost more.

Today we would like to address two sections of the proposed bill. We have narrowed our discussion to these items because they could potentially dramatically affect our professions, our workplace, our livelihood and, most importantly, our patients. I would like to point out that most hospital professionals do not refer to patients as clients or customers. This commercial terminology should be restricted to stores and salesmen.

Part I: The Ontario Health Quality Council implies a group of people who would oversee the health system in Ontario to ensure quality health service to the people of Ontario. However, Bill 8 enshrines a committee with limited abilities to report on health care in this province. It cannot judge the extent to which the health care system conforms to the principles of the Canada Health Act. It does not have the ability to report on two-tiered health care, extra-billing or user fees. By all appearances, it will be a funnel for Ministry of Health directives—a statistical reporting group with stats provided by the minister.

What happened to democracy? How will the appointments to the council be open and transparent? Will people who could gain financially from the privatization of health systems be excluded? The terms and conditions stated in Bill 8 are vague and without substance. They offer no solace to the reader. If the government is serious about forming a council that would benefit the people of Ontario and their health care system, they must allow this council to be representative of the patients, the patient advocates, front-line workers and professionals, and they must allow this council to do more than just spew statistics. This council should be empowered to make recommendations that will benefit the patients and the taxpayers. The members of this council must not be able to benefit financially from their participation on this council.

Part III: Part III of the bill was a difficult section to read due to its shocking content. Our initial impression of

this section could not be limited to one word. The terms "vague," "non-specific," "equivocal," "dubious," "ill-defined" and "obscure" all came to mind.

The most glaring issue is the lack of triggers that would determine when the minister should direct a person, an agency or an entity into any of these accountability agreements. Only the list of matters to be considered provides a hint of the governing principles.

If we look at section 20, we see statements like "value for money" and "reliance on evidence." Do we assume that the evidence showing value for money will be provided solely by the Ministry of Health?

Section 24 virtually states that all such agreements are at the whim and whimsy of the minister—one person with all this power. How does this benefit our health care system? What controls would be in place to assure fair delivery of such a broad-reaching power? The agreements could change from day to day, adding to the already chaotic health care system.

Mr Yves Shank: Section 27 flies in the face of trust, as listed in "matters to be considered." Front-line workers in our hospitals or the people of Ontario will not trust a government that considers eroding hard-earned benefits and imposes this insult by stating it is mutually agreed upon. This section of Bill 8 implies a direct threat to collective bargaining and democracy. Is this government intent on creating labour unrest and instability in our health care system?

Most hospitals in this province are still reeling from the horrible effects of the Tory agenda. In Sudbury, we dismantled a three-hospital system in forced compliance to the Tory directive. We aligned our services to meet the one-site model, and here we sit, five years later, no closer to the final goal of the glorified one-site superhospital. Although many of the programs have merged on to individual sites, each site must maintain a full complement of professional groups to answer the needs of each of the programs. This means we still require, for example, the services of the laboratory, diagnostic imaging, respiratory, pharmacy and dieticians at each site to support the individual programs. Many of the professional groups must run between sites in any given day and work in substandard conditions. For instance, at one site, we work in a lab set up in patient rooms, without adequate ventilation, lighting, proper ergonomics, storage or space.

We are facing a dangerous Canada-wide shortage of laboratory technologists. We are so short of staff in Sudbury that as of this week we have again downsized the lab at one site to cope. We cover the night shift by sending technologists when needed by cab from site to site to perform work. Our staff is wearing down and our sick-time hours are a testament to our weariness.

0840

In 1993, Canadian medical laboratory technologist training programs, excluding Quebec, enrolled 752 students in 21 programs. By 1998, the number of programs in Canada, excluding Quebec, was reduced to eight, with a total enrolment of 164. The program closures were made in response to the impact of technical advances,

health care reform initiatives, budget cutbacks and laboratory consolidations, which resulted in a significant reduction of employment opportunities for graduates. A few programs have reopened; however, the anticipated rate of retirement in the baby boom technologist workforce is creating a significant shortage. The health care system is bracing for a mass exodus of seasoned employees in 2005, when the offer of the transitional benefit available to members of the hospitals of Ontario pension plan, HOOPP, expires. This substantial monetary incentive will motivate hospital workers to access the early retirement options available.

In order to keep these seasoned employees within the hospital system and to attract students into our training programs, our local opted into a central negotiating process to achieve a contract that would meet this goal. The process was a difficult two-year, unprecedented struggle. The arbitrated outcome, although not optimal, will potentially help to slow the exodus and produce graduates. Bill 8 has the potential to negate all advances made. A reduction in compensation or an erosion of any of our benefits will force the seasoned to leave and the students to choose programs that allow fair compensation for the dangerous work we perform.

Without adequate staffing, programs will be cut. Patients will be affected by reduced access to our diagnostic and therapeutic services. Our health care system will be negatively impacted.

The workers in the Sudbury hospital system have had to adapt to decision changes imposed by administrators and ministry appointees. It is the front-line workers who continue to provide quality care to the best of their ability in spite of dramatic day-to-day modifications and reductions. We have maintained a professional, caring attitude while government promises have fallen short of the community's expectations. Bill 8 implies that front-line workers are somehow responsible for the crisis and must pay up.

We are considered the invisible workers in the hospital system. We are the diagnostic, therapeutic and rehabilitation workers. Our members took an unprecedented stand last year when the OHA attempted to arbitrarily change the rules of bargaining. We believe our members will view Bill 8 as an intrusive, undemocratic attack.

Our ability to achieve substantial improvements in compensation and working conditions is greatly inhibited by the legislation governing hospitals. The realities of our working conditions came to fruition during the SARS crisis, where we were asked to protect the health of our patients in extreme conditions, risking our own health. If this government truly believes that we are the heroes they professed in the media, then we ask that the government treat hospital workers with the respect we deserve.

Ms O'Leary: Our members want stability in the health care system. Our members want fair funding, public funds used in public institutions. Our members want safe workplaces. Our members want fair compensation for fair workload. Part III of Bill 8 must be removed in its entirety if we are to succeed in retaining

and recruiting health care professionals of the calibre we have come to expect in Ontario.

The public wants universal, portable health care. There is a collection of our seniors' memoirs of life before public health insurance called Life Before Medicare—Canadian Experiences. It depicts the hardships faced by Canadians before the advent of medicare. This book is a reality check for all those who wish to erode medicare. We ask that this government carefully consider all actions that could negatively impact the provision of health care benefits in Ontario. We ask that this government uphold its promise to stop the privatization of our health care system. We ask that this government carefully consider the full implications of this bill.

Thank you for the opportunity to address your committee.

The Chair: Thank you, Jan, and thank you, Yves. Thank you for your brevity as well. We're at 8:45. We started at 8:34, so you only used up 11 minutes, which leaves us with about 19 minutes for questions. We're going to start with the official opposition, we'll move to the NDP and then we'll move to the Liberal side to ask you questions. By my count, we've got about six or seven minutes.

Mr Frank Klees (Oak Ridges): Thank you very much for your presentation. We, too, share many concerns with you regarding this bill.

We had the opportunity to hear the Minister of Health yesterday effectively apologize for the state of this legislation. He was clearly embarrassed at the ambiguity of this bill. He was clearly embarrassed that this is the first major piece of health legislation that this government is coming forward with, and it's not a very good representation of, first of all, the principles that the preamble speaks to and what the government is suggesting that they want to do, because it leaves not only people like you, but I can tell you, stakeholders right across a spectrum of health care with many, many concerns.

Now, he did say, to his credit, that there would be wholesale amendments to this bill. He, in his statement, made reference to meetings that he has had with stakeholders, saying that he recognizes their concerns and that they are already in the process of drafting many amendments.

The concern I have is that this government doesn't exactly have a reputation of keeping its promises. In fact, there is such a huge credibility deficit that's being generated by this government in such a short period of time that, as much as I want to believe the Minister of Health when he states what he says about not intending the bill to say what it says, I have a hard time believing that when we finally see the amendments, they in fact will do what he commits them to do. I don't know about you and what sense of confidence you feel that this bill will be revised to the point where it actually does give you the kinds of protections that it speaks to or that you've asked for.

I noted one comment that the minister made in his remarks yesterday. He said accountability is a two-way

street. He's referring, of course, to the objective that he sees in this bill of bringing accountability into the health care system. I don't believe there's one stakeholder—I don't believe you would speak against accountability and health care. Very important. I think we all agree with that. The problem as we analyze this legislation is that it's far from a two-way street in this legislation. In fact, it's a one-way freeway for the minister to do whatever he chooses to do.

To the point that I think you were referring to as well in part III, section 27, some of the most draconian wording that I've ever seen glares at us from this legislation. Clause (a): "The change"—and he's referring to material changes in employment agreements—"shall be deemed to have been mutually agreed upon...."

I think one of the fundamental principles of contract law is that there is negotiation between two parties who freely enter into an agreement. In this particular case, this government is willing to set aside that freedom of the other party to enter into an agreement and simply say, "No, I, as minister, determine this is what it's going to be, and we are going to deem under law that you've actually agreed to it." I don't know about you, but to me this doesn't smack of a two-way street. It really smacks of an overpowering minister who is going to take hold of health care and is going to do whatever he chooses to do—a dangerous precedent, I believe.

I'm not confident at all that we will see the kinds of amendments that will do what we need to have done.

0850

What I would ask you to do, because you've made some good recommendations—I think it's going to be important that we get specific recommended amendments to this legislation. Coming from you as stakeholders, because I don't want to trust the government to incorporate the wording into this —

The Chair: Could you summarize, please, Mr Klees?

Mr Klees: I'm going to be looking to you, if you would, to provide us with some specific amendment wording that will safeguard these principles that we believe are so important.

The Chair: Ms Martel.

Ms Shelley Martel (Nickel Belt): Let me just deal with some questions in the order that they appear in the brief. The first has to do with Ontario Health Quality Council. Yesterday, when we had a briefing with the minister, I focused on the issue of the council because I, like you, am very worried that we might have a group of people who are very much concerned with health care but have no power to influence any change with respect to Ontario's health care system. I like your term "statistical reporting group," because I'm afraid that's exactly what this group is going to be.

If you look in the bill, with respect to the functions, they are quite narrowly defined and essentially focus on monitoring health information. The minister talked yesterday about statistics regarding obesity, diabetes etc. They have absolutely no power to make recommendations other than what they should report on, which is a

fairly limited scope and leads me to think that the minister tells them what they're going to report on and they go from there.

What are you concerned about with respect to this particular group? Do you think they're essentially just going to be there giving statistics in the way that ICES could, or do you see that they should really have some more significant, important role in actually making recommendations to the minister on health policy, on changes to health policy, on changes to health legislation, on funding? What would your vision be of a group that's supposed to be in place looking out for medicare?

Ms O'Leary: I guess in our minds, we've already seen what happens with some of these councils or the reporting-type groups. That happened with the laboratories, where they brought on board the private laboratory stakeholders to determine the state of our laboratory system in this province. When I have a look at the legislation in Bill 8 that talks about a council—we see a quality council, in my mind and in OPSEU's mind, as being a body that would have the ability to say to Canadians, "We're doing really well in this particular area of the province in our health care system and we're doing very badly in this area." It has to be put forward in an unbiased manner. It cannot be, as we've stated in our report, anybody that would have a financial stake in the outcome. We must have Canadians on a council who are interested in an end result that would provide top-notch, quality health care in this province at the best price and the best delivery system.

Ms Martel: Should they be making recommendations to the minister about funding? We need more money for public health. Obesity statistics show that that's an area we have to focus on. Should they have the ability to say to the minister, "I'm sorry, the government's just not spending enough on public health and if you want to deal with obesity rates, you've got to up the ante in terms of what you're doing at the local level through the public health units." Is that an additional function that they should be allowed to perform, given the very limited mandate they have right now?

Ms O'Leary: I think their scope should be broadened to the point that the Minister of Health would be an overseer of general projects, determining how much money might be allocated to the council to study particular issues. But the council should have a very broad mandate, and the mandate should be accountability to the public, not to the minister. It should be accountable in a way that, at the end of the year when they present their report and their recommendations for changes, the report and the recommendations should have some teeth. It can't be a recommendation for funding etc if it has no ability to go anywhere. So if they present a report, there should be some follow-through, there should be a method of monitoring what happens at the end of that process.

So if they've recommended that in this year these particular items are the most glaringly difficult or troublesome areas of our health care system, at the end of one year, their next report should also review what has

been done, what action was taken, how much money was funnelled into that particular project, so that the recommendations and any funding recommendations are made public. Any reports, good or bad, should be made public and they should be unfettered by the minister or the minister's groups.

Ms Martel: You've suggested very strongly that all of part III should just be taken out of the bill. You may know that the minister yesterday said there would be a number of changes coming in this particular section, for obvious reasons. The legal opinion provided was very clear that it was very broad and gave far too much power to the minister. We hope that we will see what he has in mind before the end of this week, but we weren't party to that yesterday in terms of receiving any information in terms of proposed wording changes. So from OPSEU's perspective, the best thing to do with all of part III is essentially to take it out at this point. Is that your recommendation?

Ms O'Leary: Yes, definitely.

Ms Martel: Let me just move on to the final point you made with respect to privatization. You said, "We ask that this government uphold its promise to stop the privatization of our health care system." I asked the minister yesterday where in the bill were the provisions to ban the for-profit MRI-CAT scan clinics, and of course there aren't any provisions in the bill to do that, just like there aren't any provisions in the bill to stop the P3 hospitals, despite the very clear election promise made by the Liberals to do both.

This is a bill that purports to want to protect medicare but says nothing about the ongoing privatization of the health care system under this government. What are your concerns in that regard?

Ms O'Leary: I guess I'd have to preface that by saying that we've already been under such tight restraint in our hospital system, and we feel that we've been backed against the wall in Sudbury. Our hospital system has been completely dismantled. We had a job line in place. They told us to perform certain tasks, make things happen. Everything was destroyed completely and put back together in a system that was supposedly going to land up on one site.

When I have a look at where we are now, which is nowhere, five years later, we're working in abhorrent conditions and our patients are not getting the quality care that they did in Sudbury. We previously had a system that was very comparable to any system in Ontario. I look at where we are now and all I see is a system that's been backed so far against the wall that now the only thing that can be said is, "Oh, well. I guess we're going to have to dump it to the private sector." I see that as the most horrible thing that could happen to our system. This would fly in the face of everything my grandparents fought for; it would certainly fly in the face of everything we need.

I have studied and worked hard on avoiding the privatization of laboratories in this province. I've watched and seen the figures. We have investigated this to the best of

our abilities. We have attempted to obtain records to prove our case. Ultimately, we know that private laboratories are going to cost more in this province. We know it. We want to stop it. I don't want to see anything else in our hospital system privatized. Any time public money goes to obtain health care in a private manner, where somebody is pocketing money, the quality goes down and the accountability is not there like we have in the hospital system. I just see privatization as the worst thing that could ever happen to our system.

The Chair: We'll go to the Liberal side now.

Ms Monique Smith (Nipissing): Thank you very much for joining us this morning. I'm very familiar with the Sudbury hospital situation, being from Nipissing right down the road, so I sympathize with you and I recognize that it's been a struggle for a long time. I also noted in the Sudbury Star over the last couple of days that, again, there's talk of the minister coming. The minister has already come to visit the hospital and he's coming back to do a summit to see how we can move forward from this log-jam position that you've been in for so long. I think that's progress and that shows a commitment on the part of our government to try and make this work and move forward with your project. So I hope to see movement there, on all our behalf, in northeastern Ontario very soon.

I wanted to address some of the concerns that you raised. I don't think you were privy to the address that the minister gave yesterday at the beginning of these hearings, so I'll make sure you get a copy of it today. I think it'll dispel some of your fears about this legislation. He spoke of some of the changes to the legislation that we're looking at.

0900

First off, he addressed the CUPE concerns, which I think are similar to your concerns about Bill 8 and its effect on collective agreements. He was clear that Bill 8 cannot open collective agreements. Unions have never been subject to accountability agreements, nor will they be subject to accountability agreements under this legislation. It will be clear in the legislation that that is not affected. So your concerns around sections 26 and 27: where those sections were specifically targeting CEOs who may have been entering accountability agreements, were never intended to have any impact on collective agreements or the workers in the hospitals—just so you know that. I'll come back to that again in a minute.

You were concerned about the structure of the councils. In the legislation, we do speak about the "desirability of appointing ... experts in the health system in the areas of patient and consumer issues and health service provision." I understand that you don't like the word "consumer," and I actually agree with you on that. Certainly we do talk about patient issues and patient concerns as being one of the voices at the table. We also talk about "governance, accountability and public finance," and "persons from the community with a demonstrated interest or experience...."

The minister spoke yesterday about keeping interest groups away from this organization, so that the stakeholder groups that are advocates on behalf of various groups would not have a place at this table. The council would be broader than that and would actually preclude those stakeholder groups from being part of that. Does that, in some way, address some of your concerns?

Ms O'Leary: I think it would, as long as the advocates are there for the patient groups.

Ms Smith: I'm sure there will be representation from user groups: people who have used the system. The purpose is to have a broad group, so that all the voices are heard at the table, and to have people who have not just one but many views or who come to the table wearing many different hats. If they've been patients and also a nurse or something, they will come to the table with different views so you can have as many voices as possible there. I think that's the intention.

"The council's mandate would be to measure the effectiveness of the system and to report on its performance in priority areas....

"The council would report to the people of Ontario about wait times for important procedures, for example cardiac care, and hip ... replacements. The council would monitor and test the effectiveness of the system through broader measures like population health status and the prevalence of serious and preventable diseases...."

I think those are some of the things you were talking about: wanting to have reports about wait times and wanting to have reports about wellness and health statistics. I understand your concern about it not being just a statistical reporting system, but I think there is a value, there being so many reports done in the system now, to having one place where they're brought together and made public. Certainly the minister has made a commitment that all reports of the council will be public. Does that address some of your concerns on the council's work?

Ms O'Leary: I think it still leaves the council as a reporting mechanism. You could possibly hire somebody from the Ministry of Health to be a reporter for such statistics. A health council, in our minds, should be a committee that could come together and make recommendations, not just report.

Ms Smith: OK.

I just wanted to go back to your concerns about the accountability agreements. The minister stated:

"Bill 8 is a big step toward greater accountability in the system. It creates a framework that allows the minister to establish negotiated accountability agreements with publicly funded health resource providers. The health care providers we intend to designate in the bill are hospitals, CCACs, long-term-care facilities and independent health facilities."

"The bill does not apply to solo physicians or group practices or labour unions, and we will offer amendments that make that abundantly clear...."

"The ministry would establish accountability agreements with the board of directors. And the board is then

required to establish a similar performance agreement with the CEO."

So the ministry would be doing the agreement with the hospital board, and then the board would have a performance agreement with its CEO. The accountability would be very much between the hospital and the ministry, and collective agreements would not be touched by this. I just wanted you to have that information as you go forward, and I'll make sure you have a copy of this statement that was made yesterday.

Ms O'Leary: Could I ask a question?

The Chair: Very briefly.

Ms O'Leary: The definition of an accountability agreement is also lacking in the bill. It leaves the term so broad. In the hospital system, we've already gone into an accountability agreement where we had a ministry appointee come in and tell us how to fix our hospital, which ended up being cut, cut, cut. We've lost programs; we've lost services. I would like to see the bill define what an accountability agreement is going to do as its end product and in its format.

The Chair: Very good. I think the point was taken. Thank you very much for coming today.

We move now to a little bit of housekeeping for the members. We have to be out of our rooms for 12 o'clock. So at some point between now and 12 o'clock, would you make your way up to your rooms and bring your suitcases down to this room.

SUDBURY AND DISTRICT MEDICAL SOCIETY

The Chair: We move on now to the Sudbury and District Medical Society. Dr Pierre Bonin is the president, and Dr Rayuda Koka is the past president. Please be seated. Would you identify yourself for Hansard when you make your presentation? You've got 30 minutes to make your presentation. You can use that 30 minutes as you see fit. Any time left over at the end of the presentation will be shared fairly among the three parties. This time we'll be starting the questioning with the NDP. The floor is yours.

Dr Pierre Bonin: Good morning, Mr Chairman and committee members. I'm Dr Pierre Bonin, president of the Sudbury and District Medical Society. Joining me today is Dr Koka, past president of our medical society and a psychiatrist in Sudbury. After my presentation, I look forward to answering any questions the committee may have.

I've been in practice in Sudbury as a family physician since 1997, and have been actively involved in the medical community in Sudbury for many years as well. This has given me the opportunity to gain valuable insight into many of the issues confronting our health care system at many levels.

Let me start by saying that my colleagues and I in the Sudbury and District Medical Society believe in a strong, publicly funded health care system that preserves the spirit of the Canada Health Act. As physicians, we see

each and every day the value our system has in the lives of our patients. However, we also see what chronic underfunding and a lack of physicians are doing to our patients, your constituents. It's clear that our system, which is based on the Canada Health Act, is not adequately meeting health care needs. From my perspective as a doctor in the north, accessibility and portability, two tenets of the CHA, are areas that are failing the test. The CHA has not been amended since its creation in 1984. It needs to be modernized or supplemented with supportive legislation. If Bill 8 is an attempt to reinforce or strengthen the CHA in Ontario, it does little to do that. While I strongly agree with the preamble of this legislation, I'm sad to say the content of the bill does not support the strong values outlined in the preamble.

One area I had hoped to be addressed in this legislation was sustainability, which is key to the establishment of a secure health care future. We need predictable funding to implement much-needed long-term planning. This will eliminate the fluctuations in funding that cause us to struggle from crisis to crisis and prevent us from retaining and recruiting the valuable physician services your constituents need. Also, vital issues such as quality and balanced accountability are not truly addressed in Bill 8.

Ensuring Canadians have timely access to the care they need speaks directly to the issue of quality. We need to set benchmarks that will give clear direction around such issues as waiting times and access to diagnosis and treatment. Two years ago, the Ontario Medical Association conducted a survey in which 90% of doctors in Ontario cited waiting lists as having a negative impact on patients' outcomes. Since then, waiting times have only become worse.

On the issue of accountability, physicians believe we all share this responsibility. The inclusion of balanced accountability in Bill 8 would ensure that all participants, including government, fulfill their obligations. Much work and significant amendments are needed to make Bill 8 anything other than, at best, a feel-good statement by this government that does not deliver real change or, at worst, that makes health care delivery more complicated and bureaucratic and in turn more harmful to my patients.

0910

In preparing my remarks for today, I had the opportunity to enlist the support of the excellent health policy department of the Ontario Medical Association. In reviewing the bill with them, I found out that it wasn't just my colleagues in Sudbury who have grave concerns about the first draft of this legislation. In fact, physicians from across Ontario were deeply troubled about the content of the bill. Subsequent to that, I have been told that only a couple of days after the legislation was introduced on November 27, the OMA raised concerns with the minister directly and ongoing discussions have been taking place among various stakeholders, the minister and the ministry to work toward making Bill 8 legislation that does not make Ontario a worse place to receive

medical care. The reason all these discussions were required is that when physicians first read Bill 8, as presented, it was clear the minister was above the law and denied due process to us in the health care system.

It is clear from Minister Smitherman's remarks before this committee yesterday that he has recognized the need for significant change in the bill. The minister recognized there were major changes needed to the tone and language of the bill. As written, Bill 8 is seen by my colleagues as an attack on the profession. The accountability section of this legislation is another area where the minister indicated he was prepared to make some change as well.

I commend the minister for being open-minded and working with stakeholders to address our real concerns over the past couple of months. This has been a good start; however, the minister and the members of this committee must make further amendments to the legislation if Bill 8 is to live up to the lofty goals set out in its introduction.

While there are several areas of the legislation I would like to address, my time before this committee will not allow me to adequately deal with all of them. Instead, we're going to focus our remarks on two particular areas of Bill 8: section 16, block fees; and subsection 9(4), which deals with payments to physicians.

Section 16 deals with what are commonly called block fees. An uninsured service is a medical service that the Ontario government does not or will not cover under OHIP. Block fees are charged by physicians to cover certain uninsured medical services. Typically, block fees include uninsured services such as telephone advice at the patient's request, renewal of prescriptions by telephone and completion of various forms and documents associated with medical assessments: drivers' physicals and that type of thing. The provision of any such service involves physician and staff time and a cost to the practice that is not billable to the ministry. Block fees should not be confused with procedures such as cosmetic surgery and uninsured diagnostic tests such as private MRIs.

Block fees are not extra-billing. They are one of two options available to patients to pay for uninsured services, as was previously mentioned. A patient has the option and freedom of choice to pay for each service not covered by OHIP as it is provided, or to pay a block or single fee to cover unlimited access to all uninsured services as outlined by the physician for a period of no less than three months and no more than 12 months. The physician must also provide the patient with a list of each fee and what the individual charge would be as an alternative to the block fee. The patient is further protected, as the decision as to which option the patient chooses cannot be a condition of the patient being accepted by the doctor.

Physicians are a self-regulated profession, and I am sure the committee supports doctors' and other allied health care professionals' right to be regulated by their professional colleges—in our case, the College of Phys-

cians and Surgeons of Ontario or CPSO. As the committee is aware, the public interest is represented, since the governing council of the CPSO as well as various CPSO policy and discipline committees have both physician and lay members.

Ten years ago, physicians, under the leadership of the OMA and in collaboration with the CPSO and the government of Ontario, set up guidelines to regulate block fees. The OMA has firmly established guidelines for third party services which most physicians rely on in setting fees for physicians. Block fees are now regulated by the College of Physicians and Surgeons under CPSO policy number 6-00. The CPSO does its role as the profession's regulator and has done a good job of educating the profession and resolving concerns about this practice. Unless government has decided that this profession is no longer self-regulating, this section must be amended.

While I do not want to get into procedural matters, the introduction of jail terms in Bill 8 is astonishing, to say the least. Subsection 17(2) provides a penalty of \$25,000 and a 12-month jail term for physicians. This seems excessively punitive and even vindictive, and makes me wonder why the bureaucrats want to go after hard-working doctors so badly. To put it in perspective, the general penalty the Provincial Offences Act allows is up to \$5,000 for statutes which otherwise do not come with a penalty. If this is the benchmark, the committee has to consider the relativity of the offences in this light. In another example, the privacy act for personal health information, Bill 31, is more important by far than block fees, yet in 100 pages of legislation in Bill 31, I cannot find a threat to put a doctor in jail.

It is my recommendation to the committee that the law specifically empower the CPSO to govern block fees, and I have submitted this recommendation to the committee in writing.

I will now turn things over to my colleague Dr Koka, so he can address section 9 of the bill.

Dr Rayuda Koka: Thank you, Pierre. Mr Chairman, members of the committee, it is my pleasure to be presenting our case here and our concerns and recommendations regarding this important bill. I am a psychiatrist practising in this community for the last 17 years, since I arrived from England 17 years ago. I'm a proud Sudburian, a proud northern Ontarian and a proud Canadian. I am proud of our Canadian health care system, and we want to see that it is sustained and survives and we continue to provide quality health care to our patients and constituents.

I'm going to address only two concerns that we have, subsections 9(2) and 9(4). As a matter of principle, we think it is crippling to legislate that not only can you not be paid more than the amount provided for by the plan, but also you may not accept payment from any person other than those listed in the section, ie, OHIP and APP, the alternative payment plan. Nothing in the Canada Health Act, CHA, requires this. I think that's important. This would prohibit many concurrent forms of practice that exist in the system now. As a result, it would affect

accessibility and patient care if we were to go through this bill. As you know, the Canada Health Act contains no such restrictions, as I said earlier on. We believe these sections will interfere with the provision of health care in Ontario. They would outlaw sessional payments for psychiatrists, which have been well recognized for a number of years, and in fact recently the number of sessions that we need to provide psychiatric care in the hospital system has increased, because they were lacking—payments to many hospital-based physicians, including laboratory physicians for their in-patient work, payment by private employers to occupational health physicians. So I would like to touch on some of the examples that I can give from my own experiences in our communities here.

For example, in psychiatry we do provide hospital services, for which psychiatrists receive indirect service payment on a sessional payment. If we were to ban it because of this bill, there wouldn't be any way to pay the psychiatrists and we would not have any psychiatrists willing to work in the hospital system.

In addition to that, we also provide outreach services in the communities in northern Ontario, plus other communities in southern Ontario as well. For example, I go to Manitoulin Island to provide service to native community services. In these community clinics, I have an agreement with the native services that I get paid for services I provide to them. With this bill, that will be prevented from charging. I could be liable and I could probably be in jail. Therefore, I think we would be affecting the greatly-needed service that we provide for the population of these communities. The same applies with the outreach program in other areas, also with the Ministry of Health programs that we have.

0920

In addition to this, in our communities, plus other communities, we have patients who don't have a family physician. Of course, I will talk about my own community here. We have a population of 30,000 in the greater Sudbury area without a family physician. When they get admitted to a hospital, they don't have a family physician to take care of them. Not only that, being a regional centre, we have regional programs in the hospital system here. When they come from outreach areas, then they don't have a family physician either. Plus, about 40% of the family physicians don't have privileges in the hospital because they are all over-worked; they don't want to have hospital privileges. So those patients will not have any family physicians either. So we have to go in a creative way to pay some other, alternative way to get the physicians to cover these patients; otherwise, there would be no patients to cover. If we were to force the physicians who have the hospital privileges to cover for these people, they would also give up their hospital privileges and walk away. The result would be a disservice to our community, our patients. Therefore, that is another flaw in this bill.

In addition to that, of course, Inco is one of the great employers here. They have an occupational health

department. Some of our physicians work in the occupational health department there and, of course, they get paid by Inco or Falconbridge or other companies as well. If we were to prevent payment from these organizations as well, it would cause problems to those patients who are cared for in these systems.

Lab medicine, I don't have to say again, is going to be a big problem. I think it is important that we should maybe extend more of these people from whom we can get paid so that it will cost the Ontario Health Insurance Plan less. As a result, I think I have indicated in my submission that the government should prohibit the payment forms it wishes to outlaw and have the ability to expand that clause by regulation. This subsection should be deleted and a subsection should establish an ability to prohibit by regulation.

I think I said section 9(4) should be amended to read: "No person or entity, other than a physician or a designated practitioner, a professional corporation controlled by the physician or designated practitioner or a facility, may charge or accept payment for the rendering of an insured service to an insured person." This would reflect the intent of the current section 15(3.1) of the Health Insurance Act.

I hope I have given some examples that will help this committee to decide in the best interests of the patients whom we serve.

Dr Bonin: In closing I would like to say that as a physician on the front lines of health care, I cannot emphasize strongly enough that our health care system is in a poor and declining spiral, and when governments make changes to the system, it should be to improve it for the benefit of patients, not to increase the power of the bureaucrats in the Ministry of Health.

Bill 8 as it stands is harmful to the system because it makes Ontario a more difficult place to deliver medicine. At a time when we need to be doing everything to recruit and retain doctors and nurses, Bill 8 will make those looking to Ontario seek other options on where to practise their valuable skills.

This is important because the numbers speak for themselves. Currently, Ontario's population is about 11 million people. It will rise to about 14.5 million people by the year 2020. Even more significant, the number of Ontarians age 55 and older will grow to represent about 30% of our population. This will mean that the number of patients over 55 will equal the current population of the entire metropolitan Toronto area.

A growing population guarantees a sharp increase in the demand for medical care. The demand is heightened when that population is aging. Government has repeatedly stated its desire to hire more doctors, yet we are having trouble keeping the ones we have. Bill 8 will drive physicians out of the province or into retirement. In either case, they are gone forever and there is no one waiting in the wings to replace them.

As your committee moves on and hears from other people, I ask you not simply for minor adjustments to the legislation but significant change so that you don't end

up making the system worse. My patients expect it and deserve it. Thank you.

The Chair: We've got approximately 10 minutes left for questions. We'll start with the NDP this time.

Ms Martel: Thank you both for being here this morning. I appreciate it. I appreciate as well that you took the time to give us some suggested amendments as we move forward with the bill.

Dr Koka, let me start with you. In terms of the amendments you gave us to 9(4), does that cover all of the examples you provided in terms of the outreach clinic at Manitoulin, Inc o etc? It covers all the possibilities of where you could be getting a payment that might now be prohibited under the bill?

Dr Koka: I think so, because if you delete the subsection and also if you put all the areas where you cannot be paid in the regulations, then that should be covered, hopefully.

Ms Martel: It's the concern about regulation that I have. With Bill 31, there will be an open process for regulation-making, where there will be a chance for public consultation. The minister referenced that sort of process yesterday but it doesn't appear in the bill in the same way as Bill 31, which has very specific references to how regulations will be done. Would it also be your recommendation that the regulation-making process be an open, public one so you see that, and that there is consultation, for example, with the OMA and others before the regs go into effect?

Dr Koka: Yes, I think it's important that the OMA be consulted, because they are deeper into it than I am. I am a practising physician. I don't know the ins and outs and what the policies are, so the OMA policy section should be able to help and suggest, I think. They were not liars either.

Ms Martel: Neither am I.

Dr Koka: We're just trying to see what is best for our patients in the practical terms of what I do now. If this were to go through as it is, then I may have to stop, my colleagues may have to stop, until I'm safe to be practising. I think the important thing is, as I indicated, we don't want the MRC here. We have medical review committee problems already; we don't want to face that here. As my friend said, we don't want to drive physicians out of this province, because they are a hot commodity. They want them everywhere, globally. I think we want to keep them here and to have them make this place more friendly. They are needed and we want them.

Ms Martel: I appreciate that.

Mr Khalil Ramal (London-Fanshawe): Thank you for your presentation. Just a question: You don't think that if you open the fee for family physicians, you will be allowing people to introduce indirectly a two-tier health care system? In the meantime, a lot of people from Sudbury have listened to the presentation from OPSEU and their opposition to a two-tier health system.

Dr Bonin: I'll answer that one. This in no way changes what we have now; it just preserves what we have now. It just doesn't make what we have now illegal

and it won't put me in jail for practising the way I am. That's all we're asking for. We're not asking for any more. There is no two-tier system here.

Mr Ramal: That's why our government is geared toward a public system and is trying to enhance it. That's especially why we introduced Bill 8, in order to tackle the whole health care issue across the province.

I come from northern Ontario. A lot of constituents come to me and complain about doctors imposing fees on them in order to give them some service. In the meantime, they believe they pay enough taxes to be covered by the ministry.

Dr Bonin: This isn't extra-billing. If you come and see me for an insured service, I cannot charge you more for that insured service. However, if you come to see me for a driver's physical, a driver's physical is a non-insured service. OHIP does not pay for that. If your company requires you to have a physical examination as a condition of your employment, that request is coming from a third party. The Ministry of Health and OHIP should not be obligated to pay for a company's need for a medically unnecessary service. Therefore, that service is being requested by a third party. It's not medically necessary and OHIP should not have to pay for it. However, I'm not going to provide the service for free. I should have an option as to how I'm going to request the patient to pay for the service, or his employer who requires the physical examination. So this isn't extra-billing.

0930

Mr Ramal: Where would we draw the line? Do we keep it open for doctors to impose any charges?

Dr Bonin: No. Actually, extra-billing is clearly illegal and any physician who is caught extra-billing will be reported to—

The Chair: Everyone wants to jump into the fray here, but we're starting to run out of time. Dr Koka, a really brief response.

Dr Koka: The block billing is regulated by the college. You have the contract between the physician and the patient, clearly telling what you're going to do for this extra-billing. So it is up to the patient whether they want to get into this contract or not. It is not a two-tier system, it is not extra-billing, nothing. We cannot put extra-billing on these patients, no.

Mr Jim Wilson (Simcoe-Grey): Dr Koka and Dr Bonin, thank you very much. I know you're extremely busy people, especially here in northern Ontario.

What the government seems to fail to understand is that you're being made scapegoats and, as a profession, you're being made to apologize for block fees. If people would recall that debate many years ago, the government didn't have the public funds available to expand the number of insured services, like telephone calls, prescriptions over the telephone and extra conferences with patients that have nothing to do with their medically necessary conditions or services. We didn't have the money to expand OHIP or the insured services, so the federal government, under the Canada Health Act, allowed some

extra fees to come in to cover you for your time and expertise. What Liberals should stop doing is campaigning that you're bad guys, charging bad fees, and actually tell the public, "We don't cover these services. Perhaps they should be insured, but we don't have the money to actually do that."

I think you should be madder than hell. I think you shouldn't put up with this. I think this room should be packed today, because people in northern Ontario—especially when you think that the minister is now going to try and regulate many of these fees or arrangements.

If I look at this town in particular, there are hundreds of arrangements between doctors, hospitals, ERs, physicians, psychiatrists, native programs, and hundreds of individuals involved. Now this bozo of a health minister is going to try and regulate every one of those arrangements. Those arrangements for the most part are in place to try and attract physicians to this community. So while you have a minute left, could you try to enlighten the government as to why special arrangements—almost as many arrangements as there are individual physicians in the system—are in place today, outside of APP or any government program, to try and get you people here? I think it's going to drive you to the United States and other places, as you said in your brief.

The Chair: You have about a minute to respond to that.

Dr Koka: It's true, we have a number of arrangements to try and attract physicians and keep the physicians in the community. Sometimes people from southern Ontario ask me how I keep psychiatrists in Sudbury, as I am the one who tried to recruit and keep them here in the summer. I have a system here that works, because of the payment system that we have, sessional payments and other incentives that we can give. But of course if that is taken away, it is guaranteed that not only will we not be able to attract anybody here but we will lose them.

Mr Klees: Mr Chairman, if I might just for one second—

The Chair: Thirty seconds.

Mr Klees: With regard to the threat here of jail time, do you have any suggestion for this government as to what bail should be set at for physicians when you're thrown in jail?

The Chair: Thank you very much for coming today. We appreciate your input.

ONTARIO FEDERATION OF LABOUR

The Chair: We're going to move on now to the Ontario Federation of Labour. We've got Irene Harris, the executive vice-president, with us today. Welcome, Ms Harris. You've got 30 minutes, the same rules as everybody else. You can use that as you wish. Any time remaining will be split among the three parties for questions, starting this time with the Liberal side. The floor is yours.

Ms Irene Harris: I want to thank the committee for the opportunity to have the Ontario Federation of Labour

here today to give you our presentation. I'm sure most of you know about the OFL, but for those who don't, we represent unions all across Ontario. We have about 650,000 members and represent all sectors, from building trades to food workers to industrial workers and education workers. We also have a lot of health care workers in our membership. So what I want to say to you today is that our presentation really covers our view of the act from two perspectives: from health care workers who work in the system and whom we hear from regularly about what they're facing, and also from members who need and use medicare regularly.

I'm not going to read the brief today. I just want to summarize some of our key points and key concerns for you and let you know where we're coming from. As a starting point, let me say, especially to the government side, that we welcome a future-of-medicare act. We recognize that the Liberal government is faced with repairing eight years of damage to our cherished public health care system. I could use all my time going through the damage we've seen done over the last eight years, but I just want to highlight a few things, because they're things we are all coping with on a daily basis.

First of all, we have to acknowledge—I see our Conservatives have left the room, but that's all right.

Ms Kathleen O. Wynne (Don Valley West): I guess they know it all.

Ms Harris: Yes, I think they're probably familiar with the damage they caused.

In all seriousness, we've had a real problem in Ontario with the delisting of OHIP services—about \$100 million worth of services. This is the kind of money the province has, so-called, saved. But what it's really done is shift those costs to people's pockets. According to statistics, individuals in Ontario pay \$1,072 per person per year in out-of-pocket costs. What is significant is that people in Ontario pay more out of pocket than any province in Canada.

We've seen incredible problems with the privatization of lab services. We've seen drug costs skyrocket. Those costs to the province have gone up 130% since 1995-96, and yet you see drug companies top the Fortune 500 list for profit-making. At the same time, our seniors have been disgracefully treated in this province. Those who are in a hospital bed waiting to get into a long-term-care facility were whacked with a \$40-a-day fee for that hospital bed.

In the home care sector we lost, across most of the province, all help for seniors with home care services. At the same time—and I'll touch on this later on home care—I want the government to note that we, as OFL, tried to find out where all this money has gone. We know that in the home care sector we lost work from the non-profit sector to the private sector. The Tories successfully privatized most home care services. We filed freedom-of-information requests to find out where that money has gone, how it's being spent and what services we are getting, only to find that the Conservatives made it so we could not access that information under freedom-of-

information requests. The way the legislation is designed, we cannot know that information. That is a disgrace. We wrote to then-Premier Eves, who said they would give us some, and gave us a lot of paper but not what we were after, and we'll be going to Premier McGuinty to try to get that information. This is the kind of thing a future-of-medicare act should deal with and should cover. It should give us this kind of access to information, and this legislation does not do that.

We've seen tremendous cuts in the hospital sector, and I'm sure you'll hear from other unions about that as you go through these hearings. But basically the loss of staff has been quite devastating. We also want to say to the government that when it comes to health care, it's more than doctors and nurses; there's a team approach in health care. When you break a leg, you need a paramedic to pick you up, and the driver of the ambulance drives you to the emergency room where a clerical person admits you. All kinds of people form together in a health care system, and we have to make sure the staff are built up.

We also saw, of course, MRIs and CAT scans moved out to private clinics. These things always used to be in hospitals, and we were insured for those services in the hospital sector. By moving them out to private clinics, that becomes very much threatened and that's where you get the two-tier system coming in. Some can buy their MRIs; some have to wait for OHIP coverage.

The Ontario Conservatives were clearly building an American-style health care system that let the private sector do the delivery. They always used to say, "We want it to be publicly funded, we want it publicly administered," but when it came to private delivery, that's really what they wanted, and we saw what they did in home care.

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Unfortunately, under this future-of-medicare act we don't see enough of this changing. Even yesterday we heard Minister Smitherman, who should know better, say, "We're for public administration, we're for public funding," but nothing about public delivery, nothing about, "Let's take all that privatization the Tories did, all the damage they did, and bring it back under the medicare house and get it publicly delivered as well." We really urge you to do something to get this dealt with under the legislation.

I also noted in his remarks yesterday that he said you're open to change and open to amendments. Clearly we've got to do something that deals with this American-style privatizing of our medicare system. This act really is the time to do that.

The preamble in the act has a lot of very positive commitments, but there are some things in the preamble that also need to be reflected in the legislation. You've got this wonderful commitment to principles, but when you read the legislation, there's nothing that puts any teeth to the principles. It's a real concern that all you're doing is keeping on that same road the Tories built, which is a very devastating one for all of us and will be

worse if you continue along that road for the next five years.

For example, on the principle of public administration, you talk about accountability and public administration. We wonder why this legislation doesn't call for the boards of all health care organizations to be elected. Why do we have private boards running things? If you go back to the home care situation, we used to have non-profit boards involved and community boards running those services. You now have the private sector running them with no community control over what home care services are given, and there's no accountability there.

I mentioned the freedom-of-information requests we're after. Why can't we know about where home care money is being spent in the private sector? What services are we getting? What are the outcomes? There's nothing in this legislation that deals with that problem.

In terms of comprehensiveness of medicare, we've seen comprehensiveness totally eroded by user fees and the delisting of services. When I first read the legislation, it was so wonderful to see an act in Ontario that talks about the need for pharmacare for catastrophic drugs, that talks about the need for home care, that talks about primary health care being essential, which it is. Primary health care will do loads to help deliver health care services in Ontario. But when you read the legislation, it's never mentioned again. There's nothing in there that says, "Here is how we're going to build this, and here is how we're going to do that." We need to hear from you how you're going to do that. Surely something called the future-of-medicare act would have those pieces in it. We need some amendments that will give us those teeth.

The other thing in the preamble that I want to highlight is a small point, but it's in the act as well. You talk about our health care being consumer-centred. When I think about being a consumer—I buy groceries, I buy TV sets—I consume products. The health care and medicare services I get, which are so important to everyone, are not something I buy. I'm not a consumer. You're a patient when you're in that system, and I think we need to get away from the business lingo that is used throughout the legislation, and that consumer-centred piece is one part of that. We're patients. We don't purchase health care per se. We have a health care system; it's a social program that we're using.

So to be clear, if the Liberal government does support medicare and has a future-of-medicare act, we urge you to put in amendments to show that legislatively we support public, not-for-profit delivery of health care. Again, publicly funded is important, and we're also specifically against for-profit health care. Health care should not be treated as a business.

With regard to the Ontario Health Quality Council, we would like to see the act more specifically spell out how appointments will be made rather than just have them made by cabinet. We're really worried, if you start appointing individuals—and I know you're saying they're not going to come from any health care organizations—that you have a lot of individuals who are into for-profit

health care. We saw that at Sunnybrook, when they started that after-hours radiation business. It was a doctor who set up that whole thing. You've got to acknowledge that within the health care system there are many who would say health care should be treated as a business and should be allowed to make profits. That goes across the board.

If you have this health council, we need something that guarantees that all views are represented and that we're not going to end up with a majority of for-profit health care people on that council. If you proceed with that, it would seem to us to make sense that if at least it is all-party appointments, if there is at least some public way to make sure we don't have people on it to see that health care is used as a business, that would be a lot better.

The other thing we'd like to see is a health council report on the extent to which the Ontario health care system is meeting the principles of the Canada Health Act and also deal with this whole issue of privatization. To what extent is the private sector intruding on health care and treating it as a business?

With regard to opting out and extra-billing, we do not agree with subsection 9(4), which allows extra-billing if permitted by regulation. All that does is take the extra-billing issue and shove it behind a closed door where government can make a regulation on items it wants to allow extra-billing on. There should be no room for extra-billing in Ontario's medicare system, end of story. And there should be nothing in this legislation that allows anything like that to happen through regulation.

The next issue I want to deal with is queue-jumping. There's a big foofaraw about hockey players not being able to go out and buy MRIs. We think the real problem with queue-jumping is that we've got too much private sector health care happening. When they took those MRI and CAT scan clinics out of hospitals and allowed them to go into private clinics, that's where there's room for queue-jumping to happen.

Physiotherapy is another example. At one time, we used to have physiotherapy in hospitals. It was very easy. Your doctor gave you a referral and you'd go to your local hospital. What we saw over time was physiotherapy being moved out of hospitals and into private clinics where you don't have OHIP coverage. They can still charge you for services and often will say, "If you go to the hospital, the waiting list can be two to three months, but if you go to your private clinic with Green Shield or Blue Cross or whatever, you get a lot faster service."

That really is a form of queue-jumping. If you're someone who has extra coverage through work, you're going to get physiotherapy faster than someone who doesn't have that and is forced to wait, sometimes up to two and three months, for hospital service. That's really the essence of queue-jumping.

If the future-of-medicare act says, "We're going to take all this lab work, all this physiotherapy and MRI and CAT scans, all these things that should appropriately be in the hospital sector where we can guarantee that all

people have coverage under OHIP," that's how we're going to deal with queue-jumping. We believe that if you have something in the future-of-medicare act that says, "We're going to recognize where the Tories privatized the system, and we're going to reverse that damage and get everything back into a publicly delivered system," a lot of these problems would get properly solved.

With regard to block fees, we don't believe they should be allowed. It's despicable that someone goes to a doctor and is told, "If you want all these other services, pay this fee up front and you'll have them covered." Some doctors don't even charge for these things.

I remember the old days, when you didn't have this problem; doctors were covered for this kind of thing under OHIP. If you have to have some kind of medical for work, why can't a doctor provide that and have coverage under OHIP? If I need a prescription renewed by telephone, why shouldn't that be covered under OHIP? What's the option? For my doctor to say to me, "If you want that prescription renewed, you're going to have to come in, have a visit and I'll charge OHIP, and then you can have your prescription"?

It's ridiculous that the system says there are now going to be some services lopped off OHIP coverage and you're going to pay for them out of your own pocket. It all goes back to one pocket or the other. Am I taking it out of my taxpayer pocket or out of my wallet pocket? I would put it to you that when you have all these extra fees, extra user fees and extra costs, at the end of the day it's the most vulnerable people, who don't have extra coverage, who don't have extra money, who can't pay for it, who get put at the end of the line or go without medical services.

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On accountability agreements: We welcomed the comments from the minister yesterday which said that would clearly not affect collective agreements and that we can look forward to amendments to that point. We were quite shocked to see the accountability agreement in the legislation. When they talked about accountability in the health care system, we thought "Great," because we do need accountability in the health care system. There's a lot that needs to be done in terms of accounting. But what you're doing in the legislation just didn't seem to make sense. We weren't sure what you were getting at and we were afraid of what you were getting at when all of the analysis was done.

In a future-of-medicare act, we think accountability should call for elected hospital boards and community control of home care, should say that freedom of information requests should exist to find out where the money's going and what programs it's being spent on. And what about whistle-blower protection? Wouldn't that be a good thing to have in a future-of-medicare act for people who want to do whistle-blowing on any problems they see? So, yes, we need accountability and that principle is important, but we just think you missed the mark on what it is we're calling people to be accountable for.

Finally, I just want to take this opportunity to urge you to take a second look at P3 hospitals, because it's very much a part of this whole future-of-medicare act. What we found is that more and more services were dragged out of hospitals and into private settings, and then when the Tories did the MRI-CAT scan clinics, you started to see more and more this eroding of health care. At one point they weren't touching hospital and physician services, but they sure were privatizing every other corner of health care that they could.

We called it privatization by stealth; that was really what was going on in Ontario. Unlike Alberta, where Ralph Klein just said, "Here's what we want to privatize," we had Mike Harris and Ernie Eves doing it by stealth in the corner wherever they could. When they moved to the P3 hospital model, they were then saying, "Here, we've found a way that we can let the private sector have a big piece in the hospital business." And let's face it, the private sector isn't there because they're good corporate citizens who don't need profit on hospitals. They need and want profit; they have shareholders; that's what they're in the business for.

You know, it's interesting; the P3 model is one they've had in Britain. We've shown over and over and seen that it costs more in the long run. I had the opportunity to be in Australia last year and met with a CEO of a hospital who told me he had been in a private hospital and in a public hospital. At the end of the day, they went back to the public model. I told him what Ontario Conservatives were doing here and he was surprised. He said, "But that's the British model. Haven't they figured out that you have essentially two bosses running a hospital? You have that private company that's going to run a whole bunch of services and then you have some things run by the public hospital board. Two masters trying to make things work in one spot." He said, "What happens in Britain is they can't even figure out, if something goes wrong in a hospital or something's out in a budget, which section of it was responsible, never mind the fact that what you're doing is privatizing certain services in a hospital that really should be in the public domain."

If the future-of-medicare act were really talking about the future of medicare in Ontario, we would need to see it say, "No more of this. We are just not going down the road of having the private sector be able to make profit from health care. We can do it better ourselves." We've shown that and that's what we need to do. We really urge you to take a second look at that P3 model. In the long run it costs you more. When it costs you more, government, no matter what government it is, is going to have to say, "How do we cut costs?" You cut costs by lowering wages or getting rid of staff or cutting services. This is not a good future of medicare for Ontario.

When you recognize the damage done in the last eight years, when you go back to the heart of it, those services that were privatized, where companies are now making big bucks off of health care in Ontario—that stuff has to get reversed. When you reverse that, you will save

millions. We urge you that there has to be that commitment in a future-of-medicare act to say, "No more privatization. We want public delivery, not private delivery."

With that, I just want to thank you and urge you to make these amendments.

The Chair: Thank you Ms Harris. We have about nine minutes left, so we'll start this time with the Liberals. Ms Smith, three minutes.

Ms Smith: Thank you, Ms Harris. We really appreciate your being here today. Certainly you've covered the waterfront. I've made notes all over the place, so I'm only going to have time to address a couple of things.

I did appreciate your bringing up the seniors issue. It's near and dear to my heart. As you probably know, I'm travelling across the province, when I'm not doing this, reviewing long-term-care facilities. So I appreciate you raising your concerns there.

I was particularly interested in your concern about the accessibility to information regarding the CCACs. That's something I will take forward and look into. I wasn't aware that freedom of information did not allow you access to that information. Certainly we will look into that.

I'm glad that you've raised the issue of accountability agreements. You recognize that they don't apply to trade unions or collective agreements. I think it is important that we have accountability between our health care providers, hospitals, CCACs, long-term-care facilities and the government, and I think it will go a long way to ensuring that we continue to have publicly funded, publicly accessible health care in the province.

You also raised an issue on whistle-blowing. In section 13(7), there is a provision for whistle-blowing protection. I was interested in whether or not you thought that needed to be strengthened or amended in some way. Maybe you could provide us with that at another time. There is some protection there for whistle-blowing for workers who report on queue-jumping. It's in the health services accessibility section. So if you'd like to get back to me later on that, we'd welcome your input.

Ms Harris: The only thing I'd say on the accountability agreements is that this act will—hopefully the amendments will say it won't affect collective agreements. But anything you do in health care does affect collective agreements. You can't make changes in a workplace and not have it, at some point, affect the bargaining table. The private sector: The company makes money; people will bargain for better wages. If they're in trouble, you have to do other things. If you go ahead and do P3 hospitals, and you're then allowing the private sector to take over major services in that hospital, the accountability agreement per se might not affect the collective agreement, but certainly bargaining will be affected by privatization of a lot of services in a lot of hospitals. That's where we're worried about what you call accountability, this notion that the minister, with the hospital boards, can know certain things or do certain things.

The accountability will come if you have elected hospital boards, if you have a fully public system, com-

munity involvement and the private sector out of it. If you're saying that's where we're going, we would say to you, yes, that's going to build in a lot more accountability than what we have now. But I think the agreements per se, while they may not affect collective agreements, what you're doing in other areas certainly will affect collective agreements.

I'll look into the whistle-blower thing. I forget the third one.

Ms Smith: Sorry, it's 14(7).

The Chair: Let's go to Mr Wilson now.

Mr Wilson: Thank you, Ms Harris. Obviously, we're going to agree to disagree on many things. I've got to give you credit; you're extremely consistent over the years anyway, in terms of your approach.

I've always wondered the following, though: hard-working people in this province pay their taxes. In order to have access to the fundamental right of work, they pay you a union due. For access to a fundamental right in our society and in many workplaces, they have to pay a union due. So how is a block fee different from a union due?

Ms Harris: I think they're very different. To me, a block fee goes to what health-related services a doctor is providing to someone. As I mentioned, I think that they should be covered by medicare, by OHIP. Union dues—you're making the comparison; I'm not sure that there is a comparison. But what I would say to you—

Mr Wilson: There's a fundamental right to work. People pay their taxes; they expect medical services. You make the point that doctors shouldn't be allowed to charge any fee above their taxes. They can't work in many workplaces without paying a union due—a fundamental right to work.

Ms Harris: But I'm saying to you that OHIP should cover those services that doctors are paying. With regard to the Ontario Labour Relations Act, it does very clearly cover services that members get for their dues, sir, so I think you might want to take a look at that act. Fortunately, you didn't touch that section of it.

Mr Wilson: Well, I have. So does the College of Physicians and Surgeons act deal with allowing the CPSO, as a self-regulatory body, to determine by regulation what's in the block fee. I just don't see the difference.

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Ms Harris: The point I'm making, Mr Wilson, is that those doctors should get paid for those services. I have no argument. If my family doctor does prescription by phone or a special thing for my employer for a driver's licence or something, they should get paid for that, absolutely. I think family doctors do a lot more than they're recognized for. They should get paid for it.

Now, the question is, should I pay out of my pocket or should OHIP cover it? We're saying OHIP should cover it, because what has happened in Ontario is that we have taken more out of our pocket and more out of our pocket to the point where Ontarians now pay more per person per year out of pocket. We have the highest rate of any province in Canada, and that was in a boom-time period. It's irresponsible, it's inexcusable and it has to change.

Mr Wilson: I don't know where you make that up. We also spent more per capita on health care than any other government.

The Chair: OK, thank you. Your time has expired, Mr Wilson.

Ms Harris: You gave it to the private sector for the profits, sir.

The Chair: OK, thank you.

Interjection.

The Chair: Jim, please. You're eating into Ms Martel's time. You have the floor, Ms Martel.

Ms Martel: Thank you, Irene, for being here today. The minister conceded yesterday that he had made mistakes in this bill in a number of areas and that there were going to be significant amendments coming forward. He said nothing, however, about the privatization of health care services, and I don't think that's an accident, because I don't think the government has any intention of changing the road they're now going down, which is a road started by my friends beside me.

I asked him very specific questions about where are the provisions in the bill to ban the private MRI-CAT scan clinics and, of course, there aren't any and there aren't going to be any, just as there are no provisions in the bill to stop the P3 hospitals and there are no provisions in the bill to stop competitive bidding in home care. That's because the government has no intention of changing the direction it's now on.

My concern is the rhetoric versus the reality. The preamble of the bill talks in glowing terms about medicare and supporting publicly funded, publicly administered services, but when the rubber hits the road, the government has no intention of ensuring that happens. What's going to happen is that important health care dollars that should be going to patients are going to end up going into the pockets of corporations, like in the P3 hospitals, like at the MRI and CAT scan clinics, like the private bidders who get home care contracts—Bayshore and others.

Can you just repeat for me the concern of the federation with respect to the preamble, which has some flowery language about recognizing medicare, and the actual contents of the bill, which do nothing—absolutely zero, nada, nothing—to stop the privatization started by the Conservatives, now being carried on by the Ontario Liberals.

Ms Harris: I think when the minister talks about medicare being publicly funded and publicly administered, he also needs to say publicly delivered, and that's the big difference. The other thing is in the preamble. The preamble is wonderful. It acknowledges the need for pharmacare, the need for home care, accountability, but then when you go to the legislation, there's nothing in there that says, "Here's how we're going to get those things started."

We recognize that we might not be able to do it all in a year, but if you had legislation that said we're going to do pharmacare, home care and come back to not-for-profit public health care, then that would be a true future-of-medicare act for Ontario. It would be something that

we could all celebrate, and it would give leadership to the rest of the country, which is really, really needed.

The Chair: Thank you, Ms Harris, for coming today. We do appreciate your input.

CANADIAN UNION
OF PUBLIC EMPLOYEES,
LOCAL 1623

The Chair: We are now going to go on to the Canadian Union of Public Employees, Local 1623, from the Sudbury Regional Hospital. Joanne Arnold is here as president. Welcome. You probably heard the rules while you were sitting in the audience. You've got 30 minutes. You can use that time as you wish. Any time that is left will be split amongst the three parties for any questions they may have of you. The floor is yours.

Ms Joanne Arnold: Thank you very much. I appreciate your time this morning. Good Morning. My name is Joanne Arnold. I am president of CUPE local 1623 of the service and clerical bargaining units of the Sudbury Regional Hospital, Northeast Mental Health Centre and Northeastern Ontario Regional Cancer Centre group. I have been a switchboard operator-communications clerk for the last 26 years at the St Joseph's Health Centre site. I'm here today on behalf of the approximately 1,000 members I represent, as well as as a member of the community and a taxpayer.

The makeup of my members who work for the hospital includes clerical employees, registration clerks, ward clerks, communications clerks, dicta typists, secretaries, health records staff, clerk typists etc. It also includes the service employees: registered practical nurses, tradespersons, food service workers, housekeeping workers, central supply and reprocessing and linen employees etc. We believe that we are the front-line workers, the nucleus of health care in this community and the province. Direct patient care runs in and out of our hands 24 hours a day, 365 days of the year.

Since 1996, we have been faced with the restructuring of insurmountable proportions of the services we provide. Recently, a local recovery plan that was put on us is a three-year roller coaster ride to hell, and it was implemented in 2003. Why? Mismanagement. Who is suffering the most for that? The patients of this community. And now the introduction of Bill 8 in the Legislature, a bill that is supposed to change the face of medicare in the province of Ontario. I will return to this subject shortly. I would like to speak, though, about P3 hospitals at this point in time.

But first we'd like to say that we're pleased to hear that the Liberal platform, prior to the election, carried the party as a whole toward the removal of the Conservative's dumping of our public hospitals into P3 hospitals and the private hands of investors. Not only have you broken this promise, but you are prepared to now add six more hospitals to be targeted by you, and to this we say shame on you.

Locally, the waiting game has begun. Once again we are all on the edge waiting for the other shoe to drop. Words like "mortgage" are being tossed about for the capital project, and we must ask you, at what cost to the patient, at what cost to this community and at what cost to the employee? How will the loan be paid back while we certainly continually run deficits, and who will be accountable at the end of the day?

Then what happens to the operating budgets? If we continue to receive less and less from the government in public dollars, that can mean only one thing, that you are prepared to open the door to privatization, and again we ask you, at what cost to the patients, at what cost to the community and at what cost to the employee? And once again, who will be accountable at the end of the day for that?

We are all smart people in this room, and we know that if the hospitals are privately owned, the privateers are their own bosses and are only accountable to themselves and their investors, and lest we forget, private companies are also in the business to make profits.

Now returning to Bill 8, in December 2003 I read the bill prior to any legal opinion placed before me. Several issues jumped out at me that gave me grave concerns, particularly around part III, accountability. To be specific, section 19 of the accountability agreements in (a) refers to the value for money and any other prescribed matter, and (d) refers to "and any other prescribed matter."

Section 20, "matters to be considered": specifically numbers "5. fiscal responsibility," "6. value for money" and "12. any other prescribed matter."

Section 21, under "accountability agreements": The Minister of Health can direct either or both to (1) enter into an agreement with him or her, or (2) enter into an agreement with him or her and any one or more persons.

Section 22, "compliance," says the Minister of Health "at any time" can issue a directive.

Section 24, under "termination," says, once again, "at any time" the Minister of Health can end an agreement he does not see appropriate and issue a new compliance directive.

Section 26 under "consequences": When the parties fail to comply, the Minister of Health then takes the ultimate powers given him with this bill and orders one or more prescribed measures.

Section 27, changes to the term of employment: Whatever orders made will be deemed, as per (a), shall be deemed mutually agreed.

Section 28, changes in funding or agreements because of funding: Once again, should funding changes occur and agreements need to be altered, as per (a), they shall be deemed mutually agreed.

So to recap this in a short fashion, the Minister of Health, in sections 19 through 28, will carry the ultimate power as it is written today to force us into an agreement. If we do not comply, then he can step in and order it done and, if he does not think it is an appropriate agreement, he can terminate it and create one of his own and order it

complied with. When funding changes occur, he then carries the power to walk in and adjust any agreement he sees fit and, again, it shall be deemed mutually agreed upon by the parties. We don't know about you, but where did we get any say in this matter?

Finally, under section 30, "non-liability," we are astounded to see the broad legal immunity tabled as protection for the powers that be, should we wish to challenge who is accountable at the end of the day.

From our perspective, we see Bill 8 as it is presented today as a serious threat, and you must realize that it is being viewed as a direct hit on our rights to free collective bargaining. We as employees of this hospital and province have the right to earn a decent living without the constant wondering if we will wake up tomorrow and be in the same boat British Columbia ended up in with their government and Bill 29.

1010

The service and clerical employees are the lowest-paid employees working in the hospital system, but the easiest target for privatization.

Our local in the last year has seen numerous cuts to the services that we provide to the patients of the Sudbury General Hospital and the community that we live in, to the tune of 73,095 hours in total. That is just in my local alone for one year. Yet we certainly have not seen any reduction of that magnitude from the management portfolio. In fact, we are seeing quite the opposite. We see a continual influx of consultants, managers and executives being hired.

The Chair: Ms Arnold, I'm sorry to interrupt you. If there's going to be conversation, out of respect to the delegation, could we have it outside the doors? OK?

Ms Arnold, I'm sorry. I just wanted to make sure you had our full attention.

Ms Arnold: Thank you.

Can someone answer this question for me: What direct patient care does additional management provide, other than doing studies and duplicating work already being done by the existing executives of the day?

To wind down my presentation today, the hospital employees of CUPE local 1623 see Bill 8 as a threat to their livelihoods, their homes, their children's education, their retirement and their physical and mental health. We have seen an increase in workloads, workplace injuries and sick time, while the services dwindle down, one day after the other, and we see no end in sight.

We bring and give a lot to the patients of this region and provide a great contribution to the economy of this community. If we do not see amendments to this bill under part III that protect our fundamental rights to maintain and uphold free collective bargaining and know that at no time will any government be able to walk in and cut our wages in half and take away our benefits that we have worked hard to achieve for years—therefore, we ask that you consider the following amendments and change Bill 8 before it becomes passed as law:

(1) No trade union shall be required to enter into an accountability agreement or be the subject of a directive;

(2) No collective agreement shall be the subject of an accountability agreement or of a directive;

(3) No accountability agreement or directive shall directly or indirectly affect the continued operation and enforceability of a collective agreement or purport to amend its terms;

(4) No employer shall be required or authorized to enter into an accountability agreement that directly or indirectly interferes with its ability to comply with the provisions of the collective agreement, nor shall any directive have such effect.

(5) Notwithstanding sections 21, 22, 26, 27 and 28, no accountability agreement entered into under section 21, compliance directive entered into under section 22, or order made under section 26 shall: directly or indirectly affect the continued operation and enforceability of a collective agreement; purport to amend, vary or discontinue the terms of a collective agreement; require the parties of a collective agreement to amend, vary or discontinue the terms of a collective agreement; directly or indirectly interfere with the ability of the parties of a collective agreement to comply with the terms and conditions of a collective agreement.

One final thought: The thought of the unlimited powers of the government to impose the options of value for money and any other prescribed matters as stated within the context of Bill 8 as it stands today will only lead to further chaos and turmoil with the hospital employees of this community and this province. The one who will suffer for this at the end of the day will be the patient.

Please consider your current position on Bill 8 and make the necessary amendments. On behalf of the approximately 1,000 members of CUPE local 1623 of Sudbury Regional Hospital, the Northeast Mental Health Centre and NEORCC, I would like to say thank you for your time and your interest in this matter today.

The Chair: Very good. Thank you. We've got about 21 minutes left and we're going to go to the PCs first, then to the New Democrats, and finally to the Liberal Party.

Mr Klees: Thank you for your presentation this morning. I think you've helped us considerably by zeroing in and actually making some very specific amendment recommendations this morning. I'm interested in your lead-up to the specifics.

We make reference to the fact that this government has broken many of its promises already, and we heard—and you will no doubt hear—the parliamentary assistant recant on many of these issues. We heard the minister in his opening statement yesterday apologize and, in fact in quite an embarrassing tone, suggest that someone made a major blunder in drafting this legislation. You've certainly picked up on it.

I have to wonder, though. First of all, I can't believe that the drafting took place in two or three minutes; I have to believe that a great deal of thought went into this. So, if in fact a great deal of thought went into it and we have the kind of draconian legislation that you have

before you—which does exactly what you're suggesting it does, by the way: override an awful lot of agreements, whether they be collective agreements or other agreements, as we heard this morning. Let me ask you this: Do you believe that the Minister of Health will make the changes that he said he's going to do?

Ms Arnold: Well, no. In all honesty, at the end of the day I think he will continue to leave the open door there. We had an emergency teleconference last night with our governing body, the Ontario Council of Hospital Unions, and I understand that there were some comments made by Mr Smitherman yesterday regarding the absolute changes that need to occur under accountability. But the one word that apparently came forth through that whole conversation was that he will not open up: "current" collective agreements. Well, let me be very clear to everybody in this room: Every collective agreement from CUPE up to ONA are opening up this year. So when I say "current," that means that when they expire, we're no longer current.

Mr Klees: You see, I don't believe him either. I don't believe very many people in this province believe very much what this government is saying. However, there is a way that this committee can at least send a strong signal to the minister, and that is if this committee would agree to move a motion to adopt the specific recommendations for amendments that you've made in your presentation.

Chair, I'm willing to make that motion for consideration by this committee. There is nothing stronger than members of the government committee here joining with us in making a unanimous recommendation to the minister to adopt these specific amendments that are being proposed. I'd like to make that motion.

The Chair: It would be my preference at this time to deal with motions after we've heard from members of the public. I'm certainly prepared to entertain that motion at the appropriate time. I leave that to the committee as to whether they would prefer to deal with the motion now or deal with it in the future.

Mr Klees: Well, there is a motion on the floor. I think if, subsequently, you want to deal with it in some other way, we can deal with the procedural matters, but I do believe you have a motion on the floor.

The Chair: I do, Mr Klees. I also have an awful lot of people who would like to speak with us today.

Mr Klees: This could take about two seconds.

The Chair: I wish it would. I have a feeling it won't.

Mr Wilson: By the way, I'll second the motion.

Ms Smith: Mr Chair, I don't believe this is an appropriate time for such a motion.

The Chair: Let me consult with the clerk. We have what I think might be a compromise—I'm hoping you'll find it to be a compromise—and that is, if you are prepared to submit that motion in writing, we would hear from the members of the public up until the noon hour; then we would take the period when we're not hearing from the public—I think that out of respect for people who have taken time out of their day to speak to us, we

would use the period between 12 and 1:30 to debate and vote upon that motion. Would that—

Mr Wilson: I'd like to speak to your comments. I don't think there's any greater respect for Joanne than to adopt what she said. You don't have any choice, by the way, as chairman when there's a motion on the floor but to deal with it, unless there was something agreed to in the—

The Chair: OK. Well, it needs to be submitted in writing to begin with. We may want to start that process going. The motion isn't officially on the floor until it's submitted in writing.

Mr Wilson: Give us one minute and it will be in writing.

Ms Martel: If it would be at all helpful in terms of timing, I would just like to indicate that I would support the motion.

1020

Ms Smith: Mr Chair, may I suggest that we move to Ms Martel's portion of the questioning so that we don't spend any more of the—

Mr Wilson: There, it's in writing.

Mr Klees: Should I read it into the record, Mr Chair?

The Chair: It needs to be photocopied and distributed to the members. So if we are going to deal with this, and it looks like we are going to set our time period back, why don't we recess for 10 minutes at this period while it is photocopied so that we all have it in front of us.

Ms Wynne: Mr Chair, is it not possible for Ms Martel to ask her questions while the motion is being photocopied? Can we not carry on and then, when the motion comes back—

The Chair: We could do that, if that's what you prefer.

Ms Wynne: I'm just suggesting that it uses the time better.

The Chair: Is that what you would prefer to do?

Ms Martel: Yes. Thanks, Joanne, for being here this morning. I want to actually focus on privatization, because there would be some in the room who would clearly understand what's happening in the hospital system in this community right now; there would be others who wouldn't, some of the committee members who are new and don't have a sense of the history.

You talked about your concern about a mortgage. My concern is that the Sudbury Regional Hospital would be one of those hospitals that will be up next for the mortgage scheme, which would be a P3 scheme. That's very much my concern. So I think it would be helpful for the committee if you could give a sense of what is happening right now, or a better way to describe it is what is not happening right now in the community with respect to construction at the hospital, which may well lead—I think will absolutely lead—to a mortgage scheme or a P3 scheme, and what kind of impact you are concerned that will have on your members, particularly because under the current recovery plan, which has nothing to do with a mortgage scheme, your members have already lost—what did you say?—73,000 hours. So

if you could just put it in that context for the committee, I think that would be helpful.

Ms Arnold: We have been sitting dormant for several years through the restructuring process. We had a south tower built, which went way over budget, extremely over budget. It was supposed to be about \$150-some million and it ended up at \$350-some million. It's absolutely ludicrous. We've had committee after committee come in. We have an empty south tower sitting there. It was supposed to be state of the art, ready to go, and it's sitting dormant. It's got ghosts in the hallways at this point.

The last government walked in and carved out the 64 long-term-care beds that were going to be initiated and put them out to St Joseph's Villa, which is going to have to build another sector in their villa in order to incorporate the 64 beds.

Again, we're still sitting empty. We're still waiting for government dollars to show up on our doorstep to complete the project. More and more we're hearing Ms Kaminski speak about a mortgage, and that mortgage is going to be very costly because they anticipate possibly taking a mortgage to the tune of paying back \$4 million and \$5 million a year out of the operating budget. If that's the case, right now we're still running a \$7-million deficit this year alone. So on top of the other \$4 million or \$5 million we have to pay back on the mortgage, that is going to cost jobs and it is going to cost services in this community.

As Ms Martel spoke about a moment ago, my local has already lost through the recovery plan, which is a whole different three-year roller coaster ride we're on, 73,000 hours. As we do the direct-patient care, the front-line workers with the patients, we're about to continue to lose this year and another year to come. The only thing that's going to affect this whole process—it's going to cost us jobs, it's going to cost the patients their services and their right to fundamental health care.

Ms Martel: It's worth pointing out that the hospital, over the three-year recovery plan, is trying to save \$20 million now.

Ms Arnold: Yes.

Ms Martel: It already has a deficit of \$7 million. It's awaiting news from the Ministry of Health about a commitment that most people in the community think was made for \$3.7 million and there has been no word from the ministry about that coming before the end of the fiscal year. So the deficit this year could be over \$10 million. On top of that, there is certainly very vocal discussion about a mortgage. When you have a mortgage, it assumes you have some savings to pay the mortgage payment. This is a hospital, since its inception, that has never had an operating saving. It's always had an operating deficit.

So what do you think it means if your members are cut, if ONA members are cut, if OPSEU members are cut? What do you think that's going to do to patient care in this community, when already the recovery plan is having a negative impact on patients?

Ms Arnold: It's going to create chaos in the health care system, because if you are going to be cutting the

services out of the hospitals, there is nothing set up in the communities for these people. It goes across all sectors of health care. It is going to mean a great deal against the patient. It is going to harm them. They are going to wait for longer times to get into the hospitals for what services remain at the end of the day. There is going to be no pushing into the process, into getting back into the system. There is nothing going to the community. There are no dollars coming from the government. We have seen several different pushes toward, "We're going to get money in Sudbury to complete this project and get a move on." Now I'm hearing we're going to have a summit. How many more sit-downs are we going to have about the Sudbury Regional Hospital to discuss how much money we need? We need dollars. We need committed public dollars to this hospital in Sudbury to complete it and deliver it publicly.

Ms Martel: Thank you.

The Chair: Ms Smith, do you have questions of Ms Arnold?

Ms Smith: Yes. I wanted to address some of your concerns that you raised in your presentation. I'm sorry I missed the beginning, but I did have a chance to review it. Thank you for providing us with a written statement.

First of all, I don't know if you have seen the statement made by the minister yesterday.

Ms Arnold: No, I did not.

Ms Smith: I'll give you a copy before you go. He's clear in his statement where he says, "Bill 8 can't open collective agreements, and unions have never been subject to accountability agreements, but we've agreed to make that more explicit."

Again, later in his statement he says, "The bill does not apply to solo physicians, group practices or labour unions. We will offer amendments that make that abundantly clear."

He doesn't use the terminology "current collective agreements." He says it does not apply to collective agreements, it does not open collective agreements. So I'm not sure where that language, that translation, came from, but it's not implicit in his statement of yesterday.

He goes on to say, "The ministry would establish accountability agreements with the board of directors, and the board is then required to establish a similar performance agreement with the CEO. We will be introducing amendments which will clarify the process for entering into accountability agreements...."

"The intent here is not to take away any of the authority of the governing executive boards, but to clarify our expectations for deliverables."

That really is the intent of the accountability agreements, to clarify what we expect as deliverables. There is an agreement between the ministry and the hospital, and it's to provide some accountability in the system that I think most Ontarians want to see. They want to know where their taxpayers' dollars are going.

I hope some of that calms your fears about the vulnerability of collective agreements. I don't believe they're vulnerable under these accountability agreements at all,

but I understand that you'll continue to have your concerns. We'll provide you with the language of the statement yesterday, and hopefully when the amendments come out, you'll be satisfied.

I also just wanted to address some of your concerns with respect to sections 22 to 26 on compliance. Again, you have concerns about the broad language that's in place on compliance directives. I think that we will be introducing some amendments there as well. We are talking about a framework right now for amendments. We will be introducing some amendments that will put more specifics around that and certainly more protections. I hope that you'll be satisfied. I would be interested to hear what you'd like to see in those areas to strengthen them or feel that you're more protected.

Ms Arnold: Well, first of all, the term "deemed mutually agreed upon" is pretty one-sided, one person making all the decisions.

Ms Smith: Just so you're clear on that, on section 26 that applies to what is in the legislation as accountability agreements between the CEO and the Ministry of Health. It doesn't affect collective agreements or individual employees.

Ms Arnold: And I understand that. I understand that you're saying that, although the bill doesn't say that. The bill is very broad and wide open at this point in time. My concern is that if you are going to have one person, even that one person making the decision about a CEO, I don't think that's accountability; I think that's a dictatorship. You need to have an elected committee that is going to make the decisions. I don't even think that compliance is appropriate. I don't think that there should be anybody in there forcing a compliance agreement. I don't even believe in the accountability agreements. I think that we need to have an open process where people become accountable through elected bodies and report back accordingly and make the changes, not just reporting back. They need to be able to make the changes as well and move forward with those changes accordingly. But it's not one person making that whole, sole decision.

1030

Ms Smith: I don't think it's the one person. In the scenario that we're developing, it would be the board that's accountable to the ministry. The hospitals do have boards in place, and the board would be accountable to the ministry.

Ms Arnold: Absolutely, and our board was appointed. So thank you very much. It wasn't elected.

Ms Smith: I think some of my colleagues have questions.

The Chair: Let's go to Ms Wynne and then to Mr Brownell.

Ms Wynne: I just had a question, and thank you, Joanne. I just want to acknowledge the turmoil that you're in here in terms of the health care system, and in just about every sector that we look at, the same kind of turmoil pertains. I think we need to acknowledge that, and so we're trying to put legislation in place that's going to prevent that from continuing and happening again.

You referenced Bill 29 from BC. As I look at Bill 29, there are really specific and very draconian statements about collective agreements and the government's ability to reach in and deem them void or change them or really disrupt the relationship between employer and employee. Can you talk about the specifics that you see in this bill? I don't see them. We've said that there are going to be changes in that accountability section, but do you see the same kind of language as in Bill 29 in this bill?

Ms Arnold: I look at what happened to my brothers and sisters in BC, as well as other people in the health care system in BC, and I'm concerned that overnight, they have lost jobs. They have had their wages cut in half. They have had their benefits taken away from them. Those are things that people have worked long, hard years for. The cost of living isn't rolling back with it. The problems in the health care system are now being retaken out on the individuals who are left behind.

Ms Wynne: So you're worried about that, but you're not suggesting that the Bill 29 language is in Bill 8.

Ms Arnold: I'm not saying it's there, but Bill 8 is so very broad right now, and the ultimate powers are very broad. You can see them. They're very much there. So it's left wide open for interpretation.

Ms Wynne: So you want that tightened up—

Ms Arnold: Absolutely.

Ms Wynne: —but I just wanted to be clear that I hadn't missed something in Bill 8, some specifics from Bill 29 that were there. Thanks.

The Chair: There's about a minute left, a minute and a half.

Mr Jim Brownell (Stormont-Dundas-Charlottenburgh): First of all, thank you for your presentation.

You mentioned about pharmacare and home care and the lack of any meat in this bill with regard to those two. You alluded to the preamble. Has CUPE or your organization had any thoughts or any written submissions with regard to what you would like to see? I know that we are saying it's important to the future of the health system, and there's nothing in here. Have you dialogued in any way with written comments that we could take back and perhaps put in so that the future will be recognized in the bill?

Ms Arnold: I personally did not speak about—what did you say? Pharmacare?

Mr Brownell: Pharmacare and home care.

Ms Arnold: I did not speak about either of those issues in my presentation. I'm sorry. There is a gentleman here, Michael Hurley, from the Ontario Council of Hospital Unions. I'm sure he will be touching base on those issues from a CUPE perspective, because he's also from CUPE.

Interjection: It was the previous person.

Mr Brownell: Oh, it was the last—I'm sorry. I wrote on the top of your paper here. I apologize for that.

Ms Arnold: That's OK.

Mr Brownell: I've been hearing that more and more and more, yesterday and today, and it's a big concern of

mine. For the last speaker, I didn't get in to comment on that. I apologize for that.

Ms Arnold: That's all right.

Mr Brownell: It's a big issue.

The Chair: Thank you, Ms Arnold, for joining us.

There's a motion that's going to be placed on the floor now. It needs to be read into the record.

Mr Klees: I move that the following amendments be adopted:

(1) No trade union shall be required to enter into an accountability agreement or be the subject of a directive.

(2) No collective agreement shall be the subject of an accountability agreement or of a directive.

(3) No accountability agreement or directive shall directly or indirectly affect the continued operation and enforceability of a collective agreement or purport to amend its terms.

(4) No employer shall be required or authorized to enter into an accountability agreement that directly or indirectly interferes with its ability to comply with the provisions of a collective agreement, nor shall any directive have such effect.

(5) Notwithstanding sections 21, 22, 26, 27 and 28, no accountability agreement entered into under section 21, compliance directive entered into under section 22 or order made under section 26 shall:

(i) Directly or indirectly affect the continued operation and enforceability of a collective agreement;

(ii) Purport to amend, vary or discontinue the terms of a collective agreement;

(iii) Require the parties of a collective agreement to amend, vary or discontinue the terms of a collective agreement;

(iv) Directly or indirectly interfere with the ability of the parties of a collective agreement to comply with the terms and conditions of a collective agreement.

The Chair: Thank you, Mr Klees. Are there any speakers to the motion?

Mr Wilson: The reason I'd second the motion is that it's consistent with the approach our party took when the social contract was being introduced. There has only been one precedent in the history of the Ontario Legislature that unilaterally opened up collective agreements, and we were very consistent in opposing that because the very nature of democracy is, whether you like what's in the agreement or not, the parties sit down and bargain. At the end of the day, they agree to live with that agreement during its term. So I commend Mr Klees for being consistent. Also, I don't see any harm in having government members support this. If the minister meant what he said, Joanne's language, madame President's language, is very consistent with following that up and putting some teeth where his mouth is.

The Chair: Thank you, Mr Wilson. Let's go to Mr Duguid, then Ms Martel.

Mr Brad Duguid (Scarborough Centre): In light of the fact that we have a number of deputants who are here today with busy schedules, I don't want to belabour this

issue. I will explain why I have difficulty supporting this at this time.

The government side is certainly looking forward to bringing forward amendments that address these concerns, and we will be doing so. We're committed to doing so. It's going to happen. To do this now, I think, is to do an injustice to all the other deputants we are ready to hear today. I think we want to hear what they have to say on this issue before we decide where we're going to go on it. I think that's part of what these hearings are for. This is highly unusual, on the first day, after hearing from three people, to start making motions and decisions. We will be moving forward in the future to address this matter, but we think it's not appropriate to be moving this motion or voting in favour of it at this point in time.

Interjections.

The Chair: Ms Martel, you have the floor.

Ms Martel: Thank you, Mr Chair. I appreciated the revisionist history by Mr Wilson here this morning, because I remember the debate on the social contract. His leader, Mike Harris, said, "Do more. Cut more. Impose the social contract now. Never mind any negotiations." He was very clear: "Cut more, fast, hard. Never mind negotiating with people; just impose the cuts unilaterally." That was Mike Harris's position, so let's just, for the record, correct what Mr Wilson had to say.

Very quickly, I'm just going to quote what the minister said yesterday in support of why the motion should be moved. He said in his remarks yesterday, "Then there's CUPE. Bill 8 can't open collective agreements, and unions have never been subject to accountability agreements, but we've agreed to make that ... explicit." I think the language that you gave to us this morning, Joanne, makes that explicit. In the absence of anything from the minister to date, because we don't have any other language before us, I think it is appropriate that we send a very clear signal that the minister means what he says. If he says what he means, these would be the references in the bill that would have to be taken out and these would be the changes that would have to be made. We should just very quickly support the changes you recommended this morning.

The Chair: Thank you, Ms Martel. Mr Delaney?

Mr Bob Delaney (Mississauga West): One very brief comment to follow on what Mr Duguid said. Joanne's points are very eloquently stated, but they're already part of it.

The Chair: Thank you, Mr Delaney. Any further speakers? Mr Klees for a second time.

1040

Mr Klees: With respect to Mr Delaney, if they're already part of this bill, pray tell where. The reason that Ms Arnold has presented these specific amendments is because they certainly are not anywhere to be found in the bill. For us to believe the minister when he told us that he would undertake to do that—I think there's a great deal of mistrust of the minister to follow through on that. This government hasn't followed through on one thing they said they would do before the election. This committee has an opportunity here to actually show some

response now to someone who took the time to make a very succinct presentation to this committee, and it's not mere rhetoric—very precise wording that does precisely what supposedly the minister said he would do.

I cannot believe that the members of the government on this committee are now doing some more sidestepping on this issue. Who has, I pray, told you people to do this? Who gave you the direction? There are six members of the committee, all members of the government. You have three members of the committee here who say, "Look, this is consistent with what the minister has said." Isn't it a coincidence that every member of the government is now taking the position that they refuse to vote in favour of this motion? Surely there's been a directive from somewhere, and this is the government that said, "We're going to do government differently."

I would ask the members opposite to think about the words of their leader during the election campaign. He said he was going to free up members of the backbench; he was going to empower members of the Legislature; he was going to make the committee process more meaningful. We have an opportunity here. I strongly urge the members of this committee on the government side to step outside of the bounds, remove the shackles that the party has put on you and vote in favour of this very commonsense motion that's before the committee now.

Ms Smith: I believe that we are living up to our commitment to actually consult the people of Ontario, which is a concept I recognize the member opposite is probably not familiar with. But we are consulting with people. We are here to listen to deputations from a number of people today and over the next week. I believe this motion is premature.

Mr Klees: Premature?

Ms Smith: Premature, yes. The minister has made the commitment and we will follow through with that.

Mr Klees: What's the appropriate gestation period?

Ms Smith: I would ask that the member actually allow me to make a statement, as I politely listened to his.

The Chair: Mr Klees, I think we all listened to you.

Mr Klees: I'd be happy to.

Ms Smith: Thank you. I just think that we should move forward. We have a number of people who are waiting to present. We're here to listen. Certainly we hope to hear a great deal more. I'm glad that we have on the record that the member opposite is committed to the sanctity of collective agreements. That's good to hear. At the risk of allowing him yet another speech, I think we should call the question.

The Chair: There was one further speaker, who I think is prepared to pass.

The motion is on the floor, then, moved by Mr Klees. All those in favour of the motion?

Ms Martel: Recorded vote, please, Chair.

Ayes

Klees, Martel, Wilson.

Nays

Brownell, Delaney, Duguid, Ramal, Smith, Wynne.

The Chair: The motion is lost.

Interjections.

The Chair: Why don't we have a recess for five minutes.

The committee recessed from 1045 to 1057.

WEST NIPISSING GENERAL HOSPITAL

HÔPITAL GÉNÉRAL DE NIPISSING OUEST

The Chair: I call the committee to order again, please. Mr Brouillette and Mr Campeau, thank you for coming this morning. I think you were sitting through the morning. You understand that you've got half an hour. You can use that any way you like and then we will split the remaining time among the three parties. The floor is yours.

Mr Raymond Brouillette: My name is Raymond Brouillette. Beside me is Yves Campeau, who is the CEO of our hospital. I am the chairman of the board of governors of the West Nipissing General Hospital, located in Sturgeon Falls, on the Trans-Canada Highway, approximately one hour east of Sudbury. Our population is predominantly of francophone origin—in excess of 75%. The West Nipissing General Hospital is one of only a few hospitals in Ontario that has achieved full designation under the French Language Services Act, 1996. I am a retired businessman and have been a voluntary member of the board for 10 years. I have been chairman for the last three years.

I am pleased with the opportunity to provide to you, on behalf of the board of governors of the West Nipissing General Hospital, our comments and concerns in regard to Bill 8.

Bill 8 is entitled Commitment to the Future of Medicare Act. On the surface no one will argue against the preservation of medicare. However, we see no evidence of linkage between the preservation of medicare and some of the current provisions contained in Bill 8.

Our hospital board of governors feels it has been broadsided by the unexpected underlying message the government is conveying by introducing this bill. Whether it was intended or not, the message being sent by government is that hospital boards and CEOs are in effect squandering public dollars without accountability and without regard for patient and community health care requirements.

One year ago, the West Nipissing General Hospital was required to submit very detailed information regarding all aspects of its operation, including governance, to the third party hospital review panel. This panel was led by Mr Al Rosen, a well-respected forensic auditor.

On March 21 of last year, I received a letter from Tony Clement, Minister of Health at the time. A copy of this letter is attached to my presentation. In his letter, the minister advised us that the government was allocating

\$300 million to Ontario hospitals to help address hospital pressures and \$50 million to reward and recognize those hospitals that were fiscally responsible and demonstrated innovation. The minister went on to inform us that the West Nipissing General Hospital's share of this new funding was \$389,500. In the absence of any information to the contrary, our board assumed that if we were granted this sum in additional funding as a result of the audit, the third party hospital review panel had to have believed that we were acting very responsibly.

In that letter the minister further stated:

"I also asked Mr Davies and Mr Rosen to provide me with an analysis of systemic issues and to submit recommendations to me in that regard.

"Their recommendations are expected in the coming weeks and will be useful to the government and hospitals as we work together to develop and build on existing strategies to strengthen our health care system, including a multi-funding framework and enhanced performance expectations.

"This government remains committed to working with you to create the right environment to foster improved care, innovation and ensure health services remain sustainable for patients."

On August 1 of last year the minister wrote to me again—copy attached. In that letter the minister stated: "I am planning to release the report of the third party hospital review panel and share the results with each hospital in the very near future. The report highlights many suggestions that would enhance the ministry-hospital accountability relationship and we will be working with you in considering how to move forward on these suggestions."

The third party hospital review report has never been released. I estimate that over \$1 million was spent to produce this report, both in direct dollars and resources allocated to the review process by both hospitals and ministry staff.

As you can see by the comments of the previous Minister of Health, it was the intent of government as recently as six months ago to work collaboratively with our hospital. You can now understand my earlier comment in regard to our board's surprise and disappointment with the direction that the current Minister of Health is taking with the government's relationship with Ontario hospitals. In its present form, Bill 8 will destroy all trust and collaboration achieved by these two important partners.

I will now summarize the amendments that we believe are required to Bill 8 in order for it to restore trust and accountability between the partners, an element that is truly necessary if we are to preserve medicare in Ontario.

The West Nipissing General Hospital believes that the health care system should be accountable to the taxpayers of Ontario and we want to do our part to ensure that this happens. However, we take issue with the way in which Bill 8 attempts to enhance accountability. We believe that the accountability provisions of Bill 8 do not sufficiently recognize the interdependent nature of the relationship

between health care providers and government, one characterized by trust, mutual respect and collaboration.

One of the most important amendments is to ensure that the accountability agreements are negotiated and not imposed. Directing hospitals to sign agreements undermines the collaborative approach adopted by both government and hospitals to develop a multi-year funding framework and performance agreements for hospitals. Imposing agreements on a hospital undermines the role of the board in ensuring that the necessary health care services are provided to the community.

Further, as currently drafted, there is no provision for multi-year accountability agreements. This is currently being contemplated by the multi-year funding initiative developed jointly by government and hospitals through the joint policy and planning committee. To build on this work and in the interests of promoting stability within the health care system, we suggest that Bill 8 should provide for multi-year agreements.

We would also suggest that compliance directives in Bill 8 are inappropriate in the context of a negotiated agreement. We are particularly concerned with what we see as yet another intrusion upon the role of the community and the hospital board, and the very real potential for undermining voluntary governance in local communities.

In particular, we cannot endorse provisions which allow the minister to make an order that may result in a material change in a person's employment, including reduction in pay or change in benefits. We propose that these provisions be deleted. Under the Public Hospitals Act, the terms of employment of the chief executive officer are the board's responsibility to determine and modify as they deem appropriate.

The bill fundamentally reduces government accountability by removing the requirement for the minister to act in the public interest as defined by the Public Hospitals Act. By removing the requirement of the minister acting in the public interest, the minister is less accountable to the public in ensuring the accessibility to health services in the community where the hospital is located. This is a serious breach of a key principle in the Canada Health Act.

We support the establishment of the Ontario Health Quality Council and believe that it could play an integral role in enhancing accessibility and accountability. However, we would suggest amending provisions in Bill 8 which at present narrowly limit its membership, function and reporting powers. Such amendments would strengthen the potential effectiveness of the council.

We believe that any initiative to enhance accessibility to publicly funded health care services must include a commitment to ensuring that there is a mechanism by which to prescribe and monitor wait times. As currently drafted, Bill 8 does not appear to address this very critical issue.

We are also concerned that section 9 may potentially prohibit payment of hospitals, laboratory physicians and other types of physicians to which hospitals make direct

payments for insured services, thereby inadvertently reducing access to health care services. Therefore, we recommend that this provision be deleted from the bill.

I would like to conclude by insisting that the West Nipissing General Hospital fundamentally endorses the intent of Bill 8 to enhance accessibility and promote accountability within the health care system. However, we take issue with the way in which these proposed changes would ultimately eliminate the collaboration developed between Ontario hospitals and the government over the past years and undermine the role of local voluntary governance of public hospitals. Therefore, we cannot support the bill as currently drafted, but look forward to seeing positive amendments to the bill once the public hearing concludes.

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The Chair: Thank you, Mr Brouillette. We're going to start the questions this time with Ms Martel. You've got six minutes.

M^{me} Martel: Merci, monsieur Brouillette et monsieur Campeau, d'être venus ce matin.

Je voudrais savoir, est-ce que vous avez une idée de pourquoi le gouvernement a changé son approche à propos des hôpitaux, à propos des conseils ? Vous avez attaché des lettres à propos du ministre qui disent qu'on va avoir de la coopération, qu'on va travailler avec les hôpitaux, qu'on va travailler avec les conseils. Mais en ce moment, nous avons un projet de loi qui est complètement contraire à propos de l'approche : on va imposer des contrats, etc. Est-ce que vous avez une idée de pourquoi il y a un tel changement d'attitude en ce moment à propos de la coopération, à propos de travailler avec vous-mêmes ?

M. Brouillette: De ma part, je crois que le gouvernement ne fait pas confiance aux gens qui sont en place. C'est une des raisons qu'ils l'ont introduit le bill. Ils veulent prendre plus de contrôle de ce qui se passe dans les hôpitaux.

M^{me} Martel: Vous avez un très bon résultat à propos du projet qui a été fait par—qu'est-ce que c'est, le nom ? The third party hospital review. Dans votre cas, il n'y a pas de problème chez vous dans l'hôpital.

M. Brouillette: Je crois qu'on a certainement réussi à démontrer qu'on faisait un bon travail chez nous, que le gouvernement n'a pas de raison de venir essayer de nous attacher les mains en arrière du dos. Si on a les mains attachées en arrière du dos, c'est difficile de faire notre travail. Comme on dit toujours en anglais, « It's a two-way street. » Il faut être capable de travailler ensemble librement.

M^{me} Martel: On doit avoir de la confiance.

M. Brouillette: C'est ça.

M^{me} Martel: Vous avez parlé d'un changement, d'amendement, et on apprécie beaucoup votre changement. Je voudrais parler un peu du conseil qui est dans le projet de loi. Moi, j'ai un problème avec le conseil parce qu'il apparaît que ce conseil est en place seulement pour « reporting » ou « monitoring ». Je voudrais avoir un conseil qui peut faire des recommandations au gouverne-

ment si on a besoin de plus de fonds, par exemple, pour la santé publique, si on a besoin de plus de fonds pour le traitement du cancer, etc. Est-ce que vous voulez avoir un mandat plus grand qui peut dire au conseil, « Vous pouvez faire des recommandations aussi », non seulement faire de la surveillance, mais faire des recommandations à propos des projets de loi de la santé, à propos des fonds pour la santé ? Est-ce que vous êtes en accord ?

M. Brouillette: Du côté des fonds, si on regarde ce qui s'est passé chez nous dans les dernières 11 années, par exemple, on a eu une augmentation de « base funding » de 1,8 %, je crois, sur une période de 11 ans, qui n'est sûrement pas satisfaisante si on veut continuer à offrir les services qui sont en place présentement, si on ne veut pas mettre de côté certains programmes.

C'est rien de nouveau. Si on regarde ce qui est arrivé du côté des salaires, du côté du coût d'équipement, du côté du coût d'énergie, continuer à opérer un hôpital avec 1,8 % d'augmentation sur une période de 11 ans, ce n'est pas acceptable. On peut couper, couper, couper, mais quand on est rendu aux os, il ne reste plus rien. Il y a quand même des limites.

M^{me} Martel: M. Campeau ?

M. Yves Campeau: Si je peux aider à répondre à la question aussi, il était clairement l'intention de notre conseil d'administration, oui, de vouloir dire que le conseil doit avoir le droit de faire des recommandations.

If it's only a reporting structure, unfortunately, I think it will not only be a waste of time, but it's going to be very difficult to find anybody with any kind of competence to want to spend time sitting on a committee if all it does is report without knowing what will ever happen to that.

Quand on parle de la constitution du comité, il est intéressant de noter que le gouvernement réserve une place sur ce comité pour un employé du ministère. Ce comité est prévu d'être de neuf à 12 membres. Si on veut avoir des gens qui ont des expertises dans tous les endroits, ça ne laisse pas beaucoup de places. Il est curieux qu'ils ont réservé une place pour un employé du ministère, mais qu'ils n'ont pas réservé des places pour une infirmière, pour un représentant de laboratoire. Why have they not reserved some places for health care practitioners, front-line workers who are on-site every day ?

Ms Martel: It's a good question. Just a final point, because you referenced waiting lists: I raised the point with the minister yesterday that Cancer Care Ontario has said since 1999 that the optimal waiting time for cancer treatment is four weeks, and they've never been able to meet that. They report annually on the fact they are not meeting their waiting times for cancer treatment. I'm not interested in another body by another name that's just going to report on waiting times when there's no mechanism for the government to have to respond to that. I'd be much happier to see a conseil that will actually make recommendations to the government that say, "Here's what you need to do to get those waiting times reduced," whether it's for cancer, for a hip replacement,

cardiac surgery, whatever it is. There's nothing in the bill that allows that now. It's just a surveillance and monitoring and reporting body, which is going to be like every other body that monitors and reports and surveys.

Mr Campeau: The most difficult task before this government and any other government, before they even talk about introducing all kinds of reporting structures, is that they have to stand up and say, "We've analyzed the resources; we've analyzed the needs. This is what the province of Ontario is prepared to promise to its constituents in terms of wait times. It's appropriate to expect to be seen within X amount." Then we can have reports, and if the reports fall short of that, then there need to be recommendations on how to improve it. But unless you establish the benchmarks, what does reporting really bring to you?

The Chair: Thank you, Mr Campeau.

M^{me} Smith: Merci, monsieur Campeau et monsieur Brouillette. Je suis très contente que vous soyez venus aujourd'hui. J'espère que la route de Sturgeon a été bonne. Ce n'est pas toujours le cas au mois de février, alors j'apprécie bien votre voyage. Vous avez noté que le ton de ce projet de loi n'était pas à votre goût. Hier, le ministre lui-même a dit dans son discours que le ton n'était pas « appropriate » quand il a présenté le projet de loi à ce comité. Je vais juste vous lire un peu de son discours pour présenter son point de vue sur le ton.

"It's clear that we didn't get the tone of the bill right in some areas. For example, the penalty provisions are too harsh. I accept that. And I want to confirm that we have listened to concerns about the penalty provisions, and will be adjusting them." Il a adressé d'autres concerns aussi dans son discours que je vais vous présenter après.

I'd like to go through some of your presentation, and I'll speak in English if it's OK, because I speak better in English on these topics; pas assez de pratique. You discussed the third party hospital review panel. I noted with interest your concern about the review and the fact that you did receive funding but never got a copy of the review report, and you noted that \$1 million was probably wasted on that exercise. One of the things we're concerned about is such exercises, and that's why we're trying to introduce more accountability into the system. As you know, my local hospital, North Bay General Hospital—and I know that you both probably deal with Mark regularly—had similar concerns where they had a review, they never got the report and they don't know what it said. They did get some money, but how are you supposed to learn from a third party review if you're not given the facts? I agree with you about that concern and I think you'll see, in future, that under this government there will not be that kind of exercise, where the results go nowhere.

With respect to the provisions in Bill 8 that you discuss in particular on page 2 of your proposal: You're concerned about accountability agreements being negotiated. Certainly we are committed to discussions and negotiations. We are committed to bringing forward a number of amendments, because it's been acknowledged

there needs to be more process, more meat on the bones. I think you'll see that we're looking at more details surrounding the negotiations, and specifically on the point of when an entity would be directed to enter into an agreement. It would certainly be after a long process of negotiations. If it were felt that it couldn't be reached, we would look at directing one. Certainly there would be a long process before that was reached.

I certainly agree with you that the joint policy and planning committee is doing some good work on multi-year funding, and I don't think that the accountability provisions we're looking at will in any way jeopardize that. We hope they will work in tandem with that.

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Again, you talked about compliance directives, and I think you'll see in the amendments that are going to be brought forward that there will be notice provisions and there will be a process followed before a directive or an order is ever issued. I think the compliance directive portion will be kind of like when you negotiate a contract and someone is in default. There's always a notice provision to allow the other side to redress before you go to the next stage. I think that's the kind of thing we were looking at in these provisions to make sure that it is a negotiated agreement and that there is give and take and there is dialogue before any actions are taken.

Certainly the ministry and the minister himself have been working with OHA in looking at the specific issues you've raised, and also particularly with respect to the public interest question you've raised. We're looking at incorporating that concept into the legislation as well.

I was interested that you noted specifically about the council—I think one of my colleagues wants to discuss with you your views on the council, but you did mention wanting to know more about wait times. The minister actually used that in his presentation yesterday as his one example about what the council could report on. So, again, I'll give you a copy of that and perhaps that will address some of your concerns about the council and reporting on wait times and looking to improve on wait times.

I certainly appreciate the tone of your presentation today. We want to continue to work together. J'apprécie bien que vous soyez venus aujourd'hui. Je vais demander à ma collègue Ms Wynne, qui avait des commentaires et des questions sur le concept de conseils. Merci.

Ms Wynne: Thank you, but I'll be doing it in English; I apologize. My passive French is better than my active French.

I just wanted to clarify your concerns about the make-up of the council. In part I, section 2, the way the wording in the bill is currently, it's fairly open in terms of considerations about who would be on this council and I think that's intentional, so that the council would look different at different points in time. Can you just talk to us a little bit about what your specific concerns are or what your specific recommendation would be.

Mr Campeau: I mentioned earlier that I think it could be more specific, and in one part the minister or the

government has indicated that they do want an employee of the Ministry of Health to be on the council.

Ms Wynne: But not as a voting member?

Mr Campeau: That's fine, but why not allow others, such as front-line workers, to also sit as members? If they decide that it's the recommendation of government that they not vote, then we would address that. But why be specific on one side? It just appears that the bill is one-sided. So when it suits the government, they do reserve a spot but don't think of the others. When we talk about the accountability agreements, they're directed, they're not negotiated.

Ms Wynne: As I see it, the specific exclusion is, "A person who is a member of the board or a senior staff member of a health system organization may not be a member of the council." Are you concerned about that exclusion or do you want more specific language around inclusion?

Mr Campeau: Obviously there are board members in the province of Ontario who could bring in excess of 30 years of experience in health care that could be very useful to council, and just by sitting on a board you no longer qualify.

Ms Wynne: So in fact it's that section that is of most concern?

Mr Campeau: That's one section.

Ms Wynne: OK. I just wanted to clarify that.

Mr Campeau: Mr Chair, could I ask one question directed to the members of the Liberal Party?

The Chair: Why don't we hear from the member of the PC party and at the very end I'll allow you that option.

Mr Campeau: Sure. Thank you.

Mr Klees: Thank you very much for your presentation. Mr Campeau, to you, I heard the parliamentary assistant indicate that she was prepared to provide you with information relating to statements made by the minister. She also said that under her government there would be no withholding of important reports such as the one to which you referred. In the presence of the committee I'm going to ask the parliamentary assistant to undertake to make a phone call this morning to ensure that you receive that report, and I'm going to ask the parliamentary assistant to confirm for us that she will undertake to provide you with the third party review report. Mr Chair?

The Chair: Certainly you can ask. It's your six minutes. Whether you choose to answer, Ms Smith, is up to you.

Ms Smith: Unfortunately, Mr Klees is again undertaking gamesmanship. I wish that you would just stick to the presentations and allow these people to have their say. Your government didn't provide them with the report. I don't know where the reports are at. I will find out what the status of the report is, but I'm unable to undertake that we will provide it to him at this time. I don't know what the status of the reports is.

Mr Klees: With respect, you are the government now.

Ms Smith: With respect, Mr Klees, it was your government that didn't provide the reports in a timely fashion.

Interjection.

The Chair: Mr Klees—

Interjections.

The Chair: Quiet, everybody.

Interjection.

The Chair: Mr Wilson.

Interjection.

The Chair: Mr Klees, you've asked the question. Ms Smith, is that your answer? Are you finished?

Ms Smith: That's my answer.

The Chair: Thank you.

Mr Klees, you have the floor.

Mr Klees: Mr Campeau, it's unfortunate. We know that that report is now the property of the current government. I would fully expect that you would receive that report, because I agree that you should have that work that was in process—it cost a great deal of money to put it together. I will be very interested. I'll certainly follow it up to ensure that now this new government that has ownership of that report, which would be very helpful to you, would release it to you. I trust that there will not be any excuses along the way not to do so.

You indicated that you have been a board member voluntarily for 10 years. Can I ask you how you feel personally, as a volunteer, about the obviously changed attitude toward board members? Number one, you are not allowed to sit on this advisory council. I heard the parliamentary assistant say earlier to another delegate that as many voices as possible should be at the table so they can hear and get input, but yours is excluded. I would suggest that probably Mr Campeau would be excluded as well. How does that make you feel, as a volunteer, about the attitude of this government?

Mr Brouillette: First of all, we're called "governors." I feel that if we are limited to a certain point where we can't properly do our work, we are not governing any more. We have to have a certain amount of liberty to do what we are supposed to do as governors. If the government puts too many restrictions on us, we just can't do it. We can't do a proper job.

Mr Wilson: Do you think, sir, this will increase your liability as a board member? It's got to be an issue. I dare say some MPPs wouldn't put up with the liability exposure you currently have as a board member, because you're not very well protected under the Corporations Act or any of the old acts. This one actually imposes not only restrictions but more onerous things to follow—paperwork to fill out and more responsibilities in terms of a performance agreement of some sort that we don't even know what it's really going to look like. Are you worried about liability, and do you think your legal fees might go up as a result of this, certainly your liability insurance? Perhaps either gentleman could answer.

The Chair: And if it could be a brief answer.

Mr Campeau: Yes. In fact, we've had discussion at the last board meeting. Not only are board members

concerned about liability, but the first step is that board members are concerned about whether they are going to be staying on. Of course, yes, we haven't seen the accountability agreements, but if it's a non-negotiated one and it's one that's directed, before signing, board members will decide, "I can live with this or not, and if it's not, I'm gone." I don't think we'll have board members who are going to put themselves in the position of being liable for something that they can't produce.

The Chair: Thank you, Mr Wilson.

Mr Campeau: My one question?

The Chair: Yes, your one question. This is it. It's brief, isn't it?

Mr Campeau: Yes, it is brief. We've heard, actually from the parliamentary assistant—and again, I apologize for not hearing the minister's speech yesterday—that the minister indicated that it was absolutely not the intent of the bill to open up collective agreements. A two-part question: Was it then the intent of the bill to open up other employment contracts, including contracts with chiefs of staff, CEOs and other senior management people at the hospitals and, if so, with what regard to contract law would that be put in?

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Ms Smith: The provision that you're referring to is going to be clarified in the amendments and it does refer to only the CEO of the organization. The CEO would enter into a performance agreement with the board and, as part of that, there would be the provision that in extreme circumstances—and we will be defining that it is in extreme circumstances—there may be repercussions to their salary if accountability measures aren't met. That's the provision that we envision in order to enforce some accountability.

But before we leave your presentation, I just wanted to make sure there was a clarification. Sorry, Chair. On the council membership, we are precluding members of health system organizations from sitting on councils. That would be stakeholder groups—and this will be clarified in the amendments as well, because there has been some discussion around what a health system organization is—but it would not preclude a board member from a specific hospital, only a member of the OHA or the OMA or the large stakeholder groups, because they would come wearing that specific hat. But it would certainly allow a board member with expertise, who has had a lot of experience, to sit on that board. I just wanted to clarify that so you didn't go away with any misapprehension.

The Chair: Thank you for that clarification. Gentlemen, thank you for coming this morning.

SUDBURY AND DISTRICT CHIROPRACTIC SOCIETY

The Chair: We'll move on then to the Sudbury and District Chiropractic Society. We have two gentlemen with us: Dr Michel Brosseau and Dr Randy Koski. Or perhaps three. Did I miss another page? No. The agenda

mentions two names and obviously there are three of you. Would the mystery person identify himself for Hansard?

Mr Fred Johnson: Yes, I'm Fred Johnson.

The Chair: Thank you. The rules are exactly the same. You've got 30 minutes to make your presentation and to use as you wish. The remaining time will be split amongst the three parties for questions. The floor is yours.

Dr Michel Brosseau: Good morning. My name is Dr Michel Brosseau. To my left is Dr Randy Koski, and you were just introduced to Mr Fred Johnson. I'm president of the Sudbury and District Chiropractic Society. Dr Koski here is vice-president. We're going to be going through, briefly, what chiropractors have as an education, our abilities, and some of the studies that have been made about chiropractic, and then Mr Johnson will be speaking as an individual who has benefited from chiropractic care as to the microcosm, let's say, of these macro-studies that Dr Koski is going to report on.

So without any further ado, I'll just pass the floor right over to Dr Koski.

Dr Randy Koski: Hopefully this will be a brief review for everyone. We've been around for over 100 years. We were founded in 1895. We have acts in all provinces and the Yukon Territory. We're the third-largest primary contact profession. What we offer is a non-invasive, preventive, holistic and drug-free approach to health now supported in the scientific literature, which we'll expand on in a second. Chiropractic traditional management of low-back pain has proven to be the most clinical and cost-effective.

Our education: we require a university bachelor's degree in approved sciences, which is then followed by four years of academic and clinical training at a chiropractic college. Our education is similar to that of an undergraduate medical training in quality and content. We focus on the neuromusculoskeletal system, using manual and drugless treatments, which is a big load on the current system. Our licence requirements include successful completion of provincial and national board exams.

Our scope of practice includes the diagnosis, treatment and prevention of disorders arising from the spine and other joints and their related tissues. We're regulated by the College of Chiropractors of Ontario, which functions the same as the College of Physicians and Surgeons of Ontario.

There have been six formal government studies confirming the clinical cost-effectiveness and safety of chiropractic, which in my mind are the top three when you look at any health intervention. They were done in Canada, USA, Britain, New Zealand, Australia and Sweden. I'm going to go over three of them.

The Meade study, which was done in 1990, was a randomized controlled trial within a real-life community setting, with several long-term follow-ups. The findings of it were that our management was more effective than hospital out-patient management, which includes a medical doctor and physiotherapist, and the results were main-

tained at follow-ups. They recommended enhanced public funding for chiropractic care to actually decrease the load and save a bunch of money, which I'll address in a second.

The second study that I'm going to go over is from the Agency for Health Care Policy and Research, the AHCPR guidelines, which are from the US, done in 1996. That entailed a literature search with 23 multi-discipline experts, and their findings were that early physical activity, NSAIDs and manipulation is supported in the scientific literature as the preferred approach for back pain.

The Mercer study in 1998 was a retrospective analysis of claims data from four of the largest Canadian disability insurers and three large national employers. Their findings were that the utilization of chiropractic care was shown to be associated with a decrease in other health benefit costs such as drug claims, short-term disability and long-term disability.

The final study that was done and commissioned by the Ministry of Health to review OHIP data for potential cost savings with chiropractic resulted in the Manga report. That came out in 1998. It was estimated that if \$200 million was spent to remove financial access barriers, our utilization was expected to increase by 10% with associated decreased utilization of the free care. It was also estimated that four out of five people who consult a chiropractor have previously been in the free system an average of six months. The overall savings over two years was estimated to be \$380 million to \$770 million in direct costs. In other words, the money would be returned back to the system as a worse-case scenario, plus \$1.25 billion to \$3.77 billion in indirect costs. When we listened to Pran Manga report this, he had said that there was no response to the study. That's confusing to me. I'm not sure where the results ended up.

What I'd like to do is turn this over to Dr Brosseau, who's going to put a local spin on these reports and apply it to the bill.

Dr Brosseau: There are 30,000 people in Sudbury without a family physician. It is our contention that, with appropriate use of chiropractic care as part of the health care system supporting the local physicians and local hospitals, we can reduce that number by 5,000 to 10,000 people without incurring any extra costs.

I'm going to pass the floor over to Mr Johnson so that you can see that when Professor Manga made the report about indirect cost-savings—Mr Johnson will be addressing his personal situation. Essentially, what we're looking at here is one case in one office. These are the kinds of situations that go on all the time in chiropractor's offices across Ontario. Take it away, Mr Johnson.

Mr Johnson: I'd like to thank everyone for giving me this opportunity to speak today. I found myself in a position over a three-year period where my health continuously deteriorated. I started out with an unlimited capacity to work. In 1999, I had seven employees and owned and ran four businesses. Then it all came crashing down.

Over the course of two years, 2000 to 2002, I was forced to close my businesses, and my wife and I sold our house at a loss to move to Sudbury to be closer to a hospital. I had tests, specialists, medications and surgeries. I regularly blacked out, fell down and was unable to pick up my two-year-old son. This is one of these things you can't believe happens to people until it happens to you.

I was caught up in a regular medical system with specialists. In one instance, I'd lost 40 pounds in one month, and the specialist's answer was to keep taking the medication and come back in four months. The math there doesn't look very good for me. He told me very clearly there was no known cause for my illness and there was no known cure. The best they could do was manage my condition.

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My family doctor filled out the forms that classified me as having a long-term disability and told me, "You know what? There are some things worse than death, and you've got it." But I'm quite thankful. I had a personality that would not accept this new life of suffering. I had saved sufficient financial resources to look for solutions, and I started by going to a naturopathic doctor. He put me on a strict diet and prescribed homeopathic medication. In 12 days my situation stabilized.

I was later referred to Dr Mike here by two nurse practitioners. They told me he had great success treating people like myself who had slipped through the medical system.

I've spent the last unemployed 18 months just trying to get healthy again, eating right, sleeping a lot, going to the gym every day and seeing Dr Mike, who is far more than a regular chiropractor. I spent about \$3,000 in the past year: \$2,000 on medication and about \$1,000 in visits to his service. The truth is, it was a bargain. I started waking up in the morning not being sick and without pain. I can go up the stairs without needing a rest. I can play with my kids. I've gotten about 80% of my life back. As I said earlier, I'm quite thankful.

I had a personality that would not accept the life I was handed and I had the money required to do something about it. In the last several years, I've met a lot of people who are sick and who simply can't afford to access the alternative medical system. The truth is, we really do have a two-tiered medical system. I also feel that if I'd had a better understanding of my illness 20 years ago and treatment options, I could have accessed our country's non-drug, private, two-tiered medical system when the symptoms first appeared. I could have avoided years of being sick and the cost to the medical system of repeated hospitalizations and surgery, and I could have been working and paying taxes all that time.

Once again, I'd like to thank you for listening to my story. Please remember, there are a lot of people out there who don't fit into our standard medical system. They fall through the cracks. They're probably not here today to speak for themselves.

Dr Brosseau: There are two points I would like to address here, and recommendations or requests—I'm not

quite sure of the correct terminology. One of them has to do with section 10. Apparently, the Ontario Chiropractic Association is not included as one of the stakeholder organizations to deal with OHIP negotiations. So I would strongly request or urge or ask that you have that happen, given the fact that we are 2,500 strong. We do a lot of work that is very effective and cost-effective for the province, so don't forget about us.

The other point is the Ontario Health Quality Council. One of the things I would like to point out is that over the last few years, Canadians have literally voted with their feet when it comes to health care. They've dished out billions of dollars on "alternative health care," as you see here in this one example. So one of the things I would strongly recommend is that on that council you have a voice or a number of voices that speak for people who are looking for natural therapies. It's not to say that we don't need the hospitals or we don't need the medical doctors we have now. Of course they're very, very necessary. But the thing is, let's not forget that there are people out there who are voting with their feet, taking charge of their own health care, seeking practitioners who are familiar, at least, with some of the alternative health care techniques—homeopaths, naturopaths, chiropractors etc.

The Chair: Very good. Thank you for your presentation. You only used up about 10 or 11 minutes, which leaves each party with six minutes to ask you some questions. We'll start with Ms Wynne.

Ms Wynne: I just want you to know that I'm only here today because I was able to go to my chiropractor before I came.

Your concerns, then, are on section 10. I just want to clarify with you that the wording that is in this bill is exactly the same as the wording in the Health Care Accessibility Act. In other words, the minister doesn't need legislative authority to enter into these kinds of agreements with other organizations. It's very possible that there are other organizations that should be listed here, but the way the wording is in the bill, the minister is able to enter into those agreements. Can you just talk about why that's problematic, and do you understand why it's been written this way? It's open, as opposed to being exclusive, right?

Dr Brosseau: As a front-line practitioner, I'm not familiar with the mechanisms of the architects of our society. So the thing is, it's a matter of when I saw that only the Ontario Medical Association, the Ontario Dental Association and the Ontario Association of Optometrists were allowed, let's say, to have negotiations with our health plan, I was going, "Oh, what's this? Are we being excluded?"

Ms Wynne: I don't know if you have a copy of the bill, but I got a call from the chiropractic association in Toronto long before we came on the hearings, and I asked this question. If you look at subsection (3), "The Lieutenant Governor in Council may make a regulation providing that the minister may enter into an agreement under subsection (1) with a specified person or organ-

ization other than an association mentioned in subsection (2)." So in fact you're covered there.

Dr Brosseau: Wonderful.

Ms Wynne: I just wanted to reassure you of that.

Do I have more time, or is that it?

The Chair: Yes, you do.

Ms Wynne: The other point I wanted to make and just ask you about was, you were worried about the representation on the council. Similarly, the language has been left open enough that in fact there can be representation from a whole bunch of different groups.

I think the issue is, to list every single person or every single organization that might be represented was seen as a problem. So the language has been left open enough that it would represent the diversity that's in the community. There are only a couple of specific exclusions, but chiropractic is not one of them.

Dr Brosseau: When the HPLR was entered into law 15 years ago, or whenever it was, I believe the College of Physicians and Surgeons put in a quality assurance program to try to keep health care quality up. The problem with that is that essentially what happened was that Dr Jozef Krop, an excellent physician who uses alternative methods, unfortunately, according to their standards, wasn't living up to their standards. In truth, he was actually exceeding the standards, but there ensued a 10-year witch hunt of a well-meaning physician.

I just wanted to make sure that those of us who are doing everything we can for patients don't get caught up in some kind of legalistic jargon that doesn't allow us to do the best that we can for the people we're working with.

Ms Wynne: The intention of this bill is to promote wellness, to set standards that are going to allow us to measure how well we're doing in terms of those wellness—and I think that discussion about allopathic versus alternative medicine is going to go on for a long time. Thank you for your points.

The Chair: Are there any other questions? There are about two minutes remaining. If not, I'll go to the PCs.

Mr Wilson: Thank you very much for your presentation. Thank you, Mr Johnson, for your personal story.

Correct me if I'm wrong, and I often am, but I think the short title of this bill is the "future of health care" act. You're not in it, nor will your patients' statistics or Mr Johnson's recovery be caught in it.

Roughly how many people, first of all, visit chiropractors in Ontario, or even in this region, on an annual basis, would you say?

Second, shouldn't we be massively worried that your profession isn't part of the future of health care in this province, by law anyway?

Dr Brosseau: This is what the thing is. I'm a little at a loss here, because they're saying that we are and you're saying we're not.

Mr Wilson: Clearly, the government, as you correctly pointed out, delineated in the act three professions that are in. Then there is the catch-all phrase that says he can also go—

Interjection.

Mr Wilson: But there are 22. I am the minister, along with Shelley Martel and Frances Lankin, who brought in the Regulated Health Professions Act, which incorporated and gave self-governance to the 22 regulated health professions in the province.

You've left out 18 regulated health professions, so why wouldn't you at least put a clause in saying that this also applies to members of the 22 regulated health professions, which are nurses, nurse practitioners—all you've mentioned are physicians, dentists and, what was the other one?

Dr Brosseau: Optometrists.

Mr Wilson: And optometrists. You've left out every other regulated health profession. So I hope—and I will bring a motion forward in that regard—that there will be some reference to all of the other health care professionals in this province.

I'll give you a chance to comment for the record because, as the government says, we're here collecting evidence, and they'll go back and think about these comments. Do you have anything on that?

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Dr Brosseau: In a nutshell, what I would ask is, whatever bills or regulations are voted on or passed through the House, allow us to do the work we're doing. Personally, I get a tremendous amount of satisfaction from seeing a person in a really bad state, and then a few months later, they're working part-time, and sometime after that, they're back to living a full life.

I realize that basically some of the negotiations here will probably affect me for the next 20 years of my career. The thing is, it's a matter that, yes, I'd like to see some consideration given to the fact that, as chiropractors, we're out here and we can not only enhance people's lives and quality of life tremendously, but also save the government of the day, whatever it happens to be, literally millions and millions of health care dollars in ancillary care, as in disability pensions etc.

It's a matter of: You guys are the architects; I'm just a front-line guy. Put the words in and allow us to do our work.

Mr Wilson: Governments have struggled with chiropractic fees. I think we pay 30% or so of the visit to, what, a \$75-dollar limit?

Dr Brosseau: It used to be \$220 maximum in a year. Then Professor Manga made the report to the government of the day. After he proved to the government that we could save them millions of dollars, the \$220 maximum was reduced to \$150.

Mr Wilson: Well, you probably didn't vote for us.

Dr Brosseau: At the time, everybody in the province was taking a hit. We did too, and that's fine.

Mr Wilson: I think governments have been slow to recognize the value of chiropractic services, and the association has consistently tried to correct all of us on that. Secondly, I think only three provinces even partially covered the fees at that time.

Do you want to comment on that? This says that from now on the government is only going to talk about people

who are currently covered or rendering fully insured services. So it actually, in my opinion, closes the door to chiropractic services. It says unless you're caught up in this bill—because this is their future vision for health care—you might as well not even have any more chats about a partial fee, let alone reinstating the over \$200.

Dr Brosseau: One of the greatest frustrations we all face, as practising chiropractors, is the barrier to access due to fees. We see people on a regular basis who could return to work, who could pick up their grandchild, who could go on with their lives, but for fate or because of their situation, they cannot access the services we can provide.

Again, I don't have the position you have, of being able to see the whole health care system. What we did today was present to you what we have as far as training is concerned, what the research has shown us and real people who come to our offices. It's up to you to look at the whole system and provide a fair and equitable future for all Ontarians. How you do that—well, that's your job.

Mr Wilson: I appreciate it. We do thank you for coming. Thank you, in particular, Mr Johnson, for giving us a real-life example of what you've been through, and the best of luck to you.

The Chair: Ms Martel.

Ms Martel: Thank you to the three of you for coming this morning.

Let me go back to section 10. It is true that much of part II of the bill, which is called Health Services Accessibility, incorporates a particular bill previously passed, which is called the Health Care Accessibility Act. It is true that the language that currently appears in Bill 8, with respect to section 10, is the same as what occurs in the Health Care Accessibility Act.

Having said that, if I look through the rest of part II, there were significant other sections added that are new and that don't appear in the former Health Care Accessibility Act. So you raise a legitimate concern about looking at section 10 and saying to yourself, "I'm excluded," just as dental hygienists would look at that and say, "I'm excluded," and the balance of regulated health professions that are not included.

It seems to me that we need to come forward with an amendment to that section that either does not specifically reference any association and leaves it all to regulation, and so allows the minister to enter negotiations with groups, or we list all the regulated health professions so there will be no misunderstanding about who is included and who is excluded. So I think there is a way to deal with that.

I don't pretend to know why in the former bill, the Health Care Accessibility Act, only three groups were listed. I have no idea. Perhaps I should, but I don't; there might be a legitimate reason. But it seems to me that to deal with your concerns and others from regulated health professions, we need to make some amendments in that section. Then it would be very clear that the minister can do these things and you can feel assured that you are going to play a legitimate role in the health care system. So we give you that undertaking.

I appreciate the concern you raise with respect to the council, in terms of the council having a representative who would speak from the perspective of alternative therapies and alternative medicine. I think you raise a good point with us this morning that that is something we should be looking at.

I have some additional concerns about the council in terms of what its mandate really is. I don't feel very happy that if it's just a group that is going to make a report to the minister, that's going to get us very far down the road in terms of either ensuring that Ontario's health care system is actually living up to the principles under the Canada Health Act or, secondly, that there is going to be any movement whatsoever on incorporating alternative therapies and medicine into Ontario's health care system.

I would much prefer to see a council that has a much broader mandate, that can actually make recommendations to the minister about changes to the health care system—legislation, policy, funding—versus just essentially reporting on health outcomes. I think there are lots of groups that can do that now. We don't need much more of that. We need to move from the outcomes to actually implementing recommendations for change. I don't know if you've had a really good look at that section and want to comment or if you feel the comments you made suffice.

Dr Brosseau: What you were saying about either list us all or don't list any seems simple to me. Then, I would add, there would be no confusion, there would be no consternation and we could move forward.

The Chair: Thank you for coming, doctors, and thank you, Mr Johnson, for your personal story.

ONTARIO COUNCIL OF HOSPITAL UNIONS, SUDBURY

The Chair: We'll go on now to the Ontario Council of Hospital Unions, Sudbury. Michael Hurley, the president, is here. You've got 30 minutes. You were here; I think you know the rules.

Mr Michael Hurley: Thank you very much for allowing me to make a presentation this morning, and thank you to the committee for traveling. It's very much appreciated that you're going throughout Ontario to have hearings.

The Ontario Council of Hospital Unions represents 27,000 members working in public hospitals in Ontario: registered practical nurses, cleaners, dietary staff, laundry staff, maintenance staff, paramedics and technologists. We represent a fairly wide range of hospital workers and clerical staff, and we've very proud of the work we do.

Last year through the SARS epidemic, we coped, with others, in the hospital system. Some of our members are still not back at work. We still have four members who have never been able to return to work. One woman brought SARS home to her twin boys, who thankfully have recovered. That kind of illness is a fact of life for people who work in institutions like hospitals.

Our average wage is \$17 an hour.

We've lived through the hospital restructuring commission—they've certainly lived through it here in Sudbury—hospital closures, transfers of programs, huge layoffs of staff, and through that entire period we've struggled collectively to try to keep Ontario's hospital system working.

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It disturbs us greatly that it appears the new government is embarking on its own reform revolution within the Ontario hospital system, driven primarily, we fear, by fiscal considerations. During the SARS epidemic, we had to close two hospitals in Ontario and the Minister of Health had to admit that the system was at the point of collapse and had no excess capacity to cope. That certainly was true of the workforce. The thought that the Minister of Health would now accrue to himself power to order institutions to transfer programs or reduce services, and would be able to reduce their funding to accomplish that, is a huge worry for us.

Frankly, we perceive Bill 8 to be an attack. I know that's a shared perception, not only among the workers in the hospital system but among its managers as well. You heard some of that this morning from the delegation from Sturgeon Falls.

The accountability provisions, which are defined as setting out performance goals and objectives, are, we fear, lifted straight from British Columbia's example of performance agreements, where hospital CEOs are rewarded with bonuses—or penalized with penalties—if they meet performance targets of staff and budget reductions set for them by the Ministry of Health. The fact that the Ministry of Health has been importing senior bureaucrats from British Columbia who may have been involved in drafting this legislation may be coincidental, but this worries us.

In British Columbia, for example, as I'm sure you know, hospital CEOs are told they have to reduce their administrative support budgets by 7%. That's their annual target. I don't know how we'll be able to cope with those kinds of staff reductions in hospitals. The SARS virus lived for a month in the North York General Hospital because the hospital wasn't cleaned properly. There aren't enough cleaners in Ontario's hospitals. That's the sad truth.

It may seem fairly easy and fiscally prudent to set a target of a 7% reduction, as they do in BC. But the outcome will be that a system that is already struggling to cope to serve the people of Ontario will not be able to with its current workforce, unless of course you reduce the compensation of that workforce, bring in private contractors, bring in people who will do the work for less money, which is the other companion piece to this that had to be introduced in BC to make the performance agreements effective; that is, legislation that allowed current collective agreements to be swept away and people to be brought in to do work. In the case of British Columbia, wages fell from \$18.50 an hour to \$9 an hour, pensions were eliminated and so were benefits. This is a

big concern to us, because the 3% wage increase our members got last September and the 3% they got before that—in fact, the 1.5% real growth in their wages over the last 25 years—is not actually the reason that health care spending is spiralling out of control.

I would pin the reasons on a few culprits, but one would be the escalating cost of drugs. There is nothing in this legislation that deals with that fact. There are huge annual increments in the cost of drugs, which are fuelling hospital budget costs. The fee-for-service system for doctors is hugely inefficient as a form of compensation and, because it pays for piecework, drives up the cost of health care.

Last, the third macro-driver that we would point to that's driving up health care spending is the proliferation of private delivery in the system. In this area, we're deeply concerned. We were very optimistic to hear during the campaign that the 21 private MRI-CAT scan clinics would be brought back into the public system and that P3—public-private partnership—hospitals would not be on the agenda for the new government. So we are very disappointed that those private clinics exist outside the system and there hasn't been any mention of them in the throne speech or subsequently from the government, that I'm aware of, and that around the P3 hospitals, not only have they not been stopped but in fact two have been approved: William Osler in Brampton and the Royal Ottawa Hospital in Ottawa.

When we met with the Ontario Hospital Association in November, they told us that there are another six in the works, including Uxbridge-Markham-Stouffville, the Salvation Army Grace in Toronto, St Joseph's in Hamilton, Grimsby, the Centre for Addiction and Mental Health in Toronto, and Runnymede. The OHA also told us that they've been meeting with the capital working group of the Ministry of Health, headed up by Michael Dechter, now the head of the Canada Health Council, and that they had a meeting of the minds that the \$8.9 billion that the hospitals require to refurbish themselves, to rebuild aging infrastructure—the OHA and the Ministry of Health have agreed that the hospitals should have unfettered access to private capital in order to be able to undertake that rebuilding.

I know there's this technical dispute going on between whether a lease or a mortgage is a preferable form of a private-public partnership hospital. From our point of view, at the end of the day, it's the bank that owns your home. If you miss payments, they actually do take it back. It has happened to some of our members. The same is true of the hospitals. So we believe these hospitals that have been approved, green-lighted, are in fact P3 hospitals.

We believe that Bill 8 is necessary to provide some degree of accountability to what will be a proliferation of private providers throughout the health care system in the hospitals and in the private clinics, that there will have to be accountability agreements. This is one of the glaring weaknesses in terms of the government's approval of the P3s, that in fact there has to be a method to make private sector interests meet the government's expectations.

There has to be a legal mechanism to require them to do that.

I'd like to talk about the P3 hospitals for a minute because in terms of accessibility, they make a mockery of accessibility. We commissioned a study by Arthur Donner, Doug Peters and Lewis Auerbach. These guys weren't union stooges or anything. One was the director of audit operations formerly for the Auditor General of Canada; one worked for Paul Martin as his under-secretary of finance; one was the TD Bank's senior economist. They calculated in a report they did, which we provided to the Minister of Health, that the borrowing costs for the P3 projects would be 14% higher than if the projects were financed by traditional borrowing. That's over the life of the contract.

We know from Britain, from the British Medical Association Journal, from the first 18 P3 hospitals that were built and studied by health economists there, that in addition to the higher borrowing costs, there were profit costs that averaged between 15% to 25% a year that had to be stacked on to the higher borrowing costs. They found that that came at the expense of access, that there would be typically 30% fewer beds and 25% fewer staff. There would be, for example, 14% fewer nurses, 38% fewer support staff.

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In terms of the accessibility-to-medicare act, if it's true, as the Ontario Hospital Association says, that we're poised to see not just two P3s but another six and then everything, then we can expect the downsizing across the hospital system of about a third of its beds. In fact, Britain has seen a radical downsizing, the largest in its history, as a result of going with the P3 schemes. We'll also see across the system 14% fewer nurses, we'll see fewer doctors and, our particular concern, 39% fewer support staff so that companies like Carillion, Amex Bank and EllisDon can have profits which are, in current terms, huge, and for 30-year contracts—or, in the case of the Royal Ottawa, a 66-year contract.

In terms of access to health care, the P3 question is a pivotal one, and unfortunately this bill is a bit of a Trojan horse. It purports to provide people with access to the health care system. It purports to impose accountability agreements on CEOs and to make them accountable, but in fact we're poised to deliver the heart of the health care system that is protected by the Canada Health Act, which is basically doctors and hospitals. That's all we've got that's covered by the Canada Health Act. The hospitals are moving over to private delivery. There will be reduced bed stock, reduced staffing levels and there will be reduced access. We will have less access to health care. That is a fundamental problem that we're going to be facing. Unless the government deals with that broader question then this is Orwellian but it's also highly cynical, because it purports to provide to people some legislated guarantee, and it's only actually necessary because their legitimate and current right to access the system is evaporating because of government policy as we speak. There are some fundamental problems around this.

In British Columbia, where the performance agreements are modelled on, the attack is on the support staff. People have decided they can reduce hospital budgets if they can pay people half of what they're paying them now—the clerical staff and the cleaners and the people who make the food—and if they can roll back the nurses' salaries they can effect savings while sending huge, unprecedented, unbelievable sums of money in profits to corporations, many of them foreign corporations, which have come to feed on the health care system which is our pride in Canada.

When we reviewed Bill 8 and had a lawyer review it, we were disturbed to see that the accountability agreements appear to be lifted from British Columbia in terms of a way for government to coerce managers to wring savings from the system, again while ignoring the macro-drivers, the drug companies and the private delivery, which are actually the culprits in the escalating costs here.

In terms of the matters to be considered, like value for money and fiscal responsibility, if nurses were to consider value for money, they'd be working in Texas, not in Ontario. It disturbs me to read in Minister Smitherman's comments yesterday that he favours a consumer-centred health care system. Consumer, purchaser, buyer of services: That isn't the health care system that I've grown up in where, as a fundamental right of citizenship, I have access, irrespective of my ability to buy services, to doctors and hospitals.

The criteria, including, of course, number 12, "any prescribed manner," which is consistent through the legislation—so much of this accountability section is left to subsequent cabinet regulation to define, and it freaks us right out. It worries us greatly, because this is such a central part of the Ontario public sector. The ability of the minister to issue directives compelling people to act; the ability to vary those directives at any time; the ability to deem people to be in compliance with those directives, to break employment contracts, to reduce wages or benefits, to make people comply and define them, all supposedly in pursuit of accessibility—these provisions have us mystified.

We've been reassured that it's not the intent of the government to attack collective agreements. In communication we had from the minister's staff to CUPE, there was a reference to current collective agreements. The minister made that reference in his scrum yesterday. I just point out to you that we have centralized bargaining in our sector, where nurses have a collective agreement and technologists do and support staff do—master agreements—so we don't spend a lot of taxpayers' money in futile replications of the same pattern. But all those agreements are up this year: ONA's and OPSEU's for nurses and technologists expire March 31; support staff agreements start expiring September 28; then October 4, they're all open. So when people talk about, "Don't worry; your current collective agreements are protected," that's not very reassuring to us; not at all.

We would ask you to reconsider the accountability provisions. Joanne Arnold from the Sudbury Regional

Hospital proposed amendments around the collective agreement concerns, and we'd certainly like you to take a look at those. But frankly, the accountability provisions are hugely flawed, and there's no way that any genuine reform of the health care system in Ontario can be accomplished overnight in a hastily written bill and then cobbled together with amendments that satisfy different constituencies when what's really required is an honest and democratic discussion about the health care system and its needs and the problems that are facing us, and some legislation that follows from that kind of process that perhaps, ideally, we could all endorse. So I really appreciate your giving us the opportunity to make a presentation to you this morning.

The Chair: That's wonderful, Mr Hurley. Thank you.

We've got about 12 minutes left, four minutes for each party, starting with the PCs.

Mr Klees: Thank you, Mr Hurley, for your presentation. You made reference to the amendments that were proposed by Ms Arnold. I don't know if you were here before, but we moved a motion here to in fact adopt those. You saw the members of the government vote against those. Does it concern you that there is an outright rejection on the part of the government members of this committee of those amendments?

Mr Hurley: It worries us, Mr Klees, because we were quite believing of the commitments that were made around the P3 hospitals, and now we have a profound difference of opinion with the government about whether we have P3s or not. We think we do; they say they don't.

These are not trivial matters for members and their families. They go to the ability of people to live and feed their kids and send them to college and stuff. So it isn't enough for us to hear reassurances and it certainly was disturbing. I'm just hoping that, in the processes that you have, we will see amendments. We won't actually be reassured until we actually see amendments for sure.

Mr Klees: Given the fundamental flaws of this legislation, it's interesting—whether it be the employee sector, whether it be the professionals, whether it be chairs of boards, there hasn't been a stakeholder who has come forward who has applauded this bill. It is so fundamentally flawed even the minister was embarrassed. I don't know how a minister could allow this legislation to get this far and then have to appear before a public committee to say, "I'm embarrassed at what I'm bringing forward," unless the minister didn't read the bill before he came to committee. But given its fundamental flaw, would you agree that it's probably in the public interest for this bill to be withdrawn and that truly we look at the principles you've outlined—in fact, the principles in the preamble are not bad—and go back, and start from day one here to build something, as you say, in a conciliatory way that actually gets us closer to where we need to be?

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Mr Hurley: It would certainly be our preference, Mr Klees, that the legislation be redrawn and there be a genuine process that was consultative and democratic

that could allow people to talk about some of the challenges the bill purports to attempt to address.

The Chair: Thank you, Mr Klees.

Ms Martel: Thanks, Michael, for being in Sudbury today. I want to focus on the privatization. You had a meeting, I gather, with the minister on January 13, yourself and Sid Ryan. Can you tell the committee what Mr Smitherman had to say about P3 hospitals?

Mr Hurley: We had a disagreement about whether or not there were P3 hospitals, but he did say that there were another six hospitals that had requested the opportunity to explore access to private capital. He disputed the comment that had been made by the president of the Ontario Public Services Employees Union at the Centre for Addiction and Mental Health who had said she had been told by her CEO that he had been told by the minister that they had been green-lighted for a P3. He disputed that, but he did say that these were in the works. They wouldn't look like Brampton and Ottawa, but no decisions had been made at this time on those six. Subsequently the Star said there were seven.

Ms Martel: Did he say anything about the private MRI and CAT scan clinics?

Mr Hurley: No.

Ms Martel: So we have before us a bill that in the preamble purports to recognize medicare and purports to affirm our commitment to universality, portability, accessibility, comprehensiveness etc, except the bill says nothing about stopping further privatization of health care services. So the bill says nothing about stopping the two P3 hospitals in Brampton and Ottawa, which will use public money that should go to patients and instead line the pockets of the private consortiums that are going to build the hospitals, not to mention the six others that are coming. It says nothing about cancelling the private MRIs and CAT scans, which of course the government promised to do before they were elected. Noting that, what do you think about a preamble that talks in glowing terms about medicare in a bill that does nothing to stop the privatization that the Conservatives started and the Liberals are now embracing and moving forward on?

Mr Hurley: I regret having to say this, but I'm afraid it's a bit of doublespeak, actually. It's a bit of a smoke-screen. People are being reassured, and certainly all the hoopla was around Mrs Smith in rural Ontario, who would have access to these services and wouldn't be queue-jumped by a Toronto Maple Leaf player or something. That all sounded very positive, but pursuing the policy of privatization simultaneously with purporting to provide accessibility is completely inconsistent. The privatization policy will dramatically undermine accessibility, and it will mean that Mrs Smith, at the end of the day, will be queue-jumped, no question about it.

Ms Martel: If you thought the government was serious about protecting medicare and protecting publicly funded, publicly administered, publicly delivered health care services, what would you see in this bill with respect to trying to implement that? I'm thinking specifically about the current services that are privatized, that the government now seems not intent on reversing.

Mr Hurley: The government would be taking measures in the legislation to reacquire into the public delivery system those private clinics and those private hospitals. This is a fundamental question of health policy. If you think health care spending is unsustainable now and if you think the system is strained now, then adding another 30% in terms of costs can only make the system more expensive and diminish accessibility. It's a fundamental question facing the health care system that can't really be ignored. It should be, you would think, addressed in this kind of legislation.

Ms Smith: Thank you, Mr Hurley, for coming and sharing your views with us. I think you and I will probably agree to disagree on a couple of things, as you have with the minister. I would point out that the government has ensured that the two hospitals you addressed continue to have ownership and control of the facilities and the health care services are delivered publicly and the taxpayer investment is sound.

With respect to the six others that you mentioned, that you kind of suggested were heading toward privatization, I just want it to be clear that no decision has been made with respect to any other arrangements with respect to other hospitals. The ministry is working in concert with the Ministry of Public Infrastructure and Renewal on a health infrastructure financing and procurement framework to be applied to emerging hospital projects, and the framework will be based on the key principles of public ownership, public accountability and public control. I think you're aware of that, and I do believe you've misled somewhat by indicating that there has been a deluge of private hospitals developing around the province.

That being said, I would like to just speak to you for a moment about your concerns with respect to Bill 8 and the linkages that you've drawn to BC legislation. Actually, before we move to that, I would just like to point out in response to something my colleague Mr Klees said when he was in the room, that this legislation has been brought forward precipitously, that I think it's a statement about this government that we've brought forward this legislation for public consultation after first reading. I think it's important that we get public consultation and input into making this bill the best bill possible in order to protect medicare. So I appreciate that people like you are coming out and giving us some constructive criticism and some concerns, but I do want it acknowledged that it was brought forward after first reading, which is early in the process, and I think we all agree that some improvements can be made, and certainly the minister made that point yesterday.

With respect to the BC legislation, I would ask you to just point out for me exactly where you see the similarities lie between the BC legislation, which we have had the privilege of taking a look at, and this legislation, because I see nowhere in this legislation where we address collective agreements or that collective agreements are going to be opened up or that there will be the ability of boards of hospitals to do such a thing.

Mr Hurley: You shouldn't confuse our concerns around Bill 8 with our criticisms of BC's Bill 29, which was legislation aimed directly at health and education sector collective agreements. But Bill 8 does allow the cabinet to define those people who will subsequently be the target of ministerial orders that could have the effect of breaking their employment contract or downgrading their wages and benefits. That's clear. We have a legal opinion which we'd be happy to share with you around that.

Also, Bill 8, in defining health service providers or entities, leaves room for trade unions to be captured by the definition of "entity." So these compliance directives—the similarity with BC is around your accountability agreements, which are modeled on the performance agreements in British Columbia and which target savings in support and administration sectors and reward or penalize CEOs based on their ability to reduce their budgets in those areas. That is alarming because hospitals are already short staffed.

Ms Smith: I would just question how you come to the conclusion that our accountability agreements are modeled after the BC performance agreements. Where are you drawing that from? I would also question, just as a second part, when you talk about fiscal responsibility and value for money. There are 12 issues, as you noted, related to accountability agreements. I think you would agree with me that shared and collective responsibility is one that we'd like to see in accountability in our health care system, that transparency is something we'd like to see. Would you agree with me that transparency is something you'd like to see?

Mr Hurley: I'd like to see the government be accountable to the people of Ontario for its health policy. I think that in terms of this legislation, unfortunately the government is introducing policies which are going to dramatically undermine accessibility. In this legislation, you're shifting all of the burden to the people who work in institutions, in terms of their accountability to you. There is none flowing the other way. That's the debate I'm trying to engage you in.

With respect to credibility, we can split hairs with an axe over the question of the P3 hospitals. We thought we had a clear commitment around the P3 hospitals; now we don't. So I think you can understand, then, that when you tell us that we have nothing to fear in this legislation, you have a credibility deficit with us that can only be addressed by seeing some significant amendments.

Ms Smith: I think we have indicated that there will be amendments brought forward, specifically with respect to collective agreements and the effect of this legislation on unions. That has been stated over and over. You've seen the statement by the minister. I understand you want to see the writing, and you will in time see the writing. If I could just—am I out? I'm done?

The Chair: You're actually over. I thought that was a great summary by you both. Thank you very much, Mr Hurley.

We stand recessed until 1:30.

The committee recessed from 1233 to 1335.

CANADIAN UNION OF PUBLIC EMPLOYEES, LOCAL 139

The Chair: We're going to call back to order again. Our next delegation is from Mr Bill Kotsopoulos, the president of the Canadian Union of Public Employees, Local 139, Sudbury.

Mr Kotsopoulos, would you come forward. Please have a seat wherever you feel most comfortable. You have 30 minutes to make your presentation. You can use that any way you choose. At the end of your presentation we'll split the remaining time among the three parties. This time around the questioning will start with Ms Martel. The floor is yours.

Mr Bill Kotsopoulos: Thank you for the opportunity to speak here this afternoon. I am the president of CUPE local 139. We serve approximately 530 members in our union, both service and clerical. We all work at the North Bay General Hospital in North Bay. You'll have to excuse us for our tardiness this afternoon. About 14 of us drove up from North Bay and we got lost in Sudbury, so thank you for your patience.

The question I'd like to have you consider is, why are hospital workers up in arms about Bill 8? A usually mild-mannered group, very kind and generous, always giving in the hospital setting, this group of people has become very concerned with Bill 8. I'm sure you've had very many other speakers this afternoon talk about different aspects and parts of the bill. The one that concerns CUPE local 139 in North Bay is the collective agreement and what possibilities the government may have in dismantling our collective agreements. This is the main point I would like to stress this afternoon.

I'm sure you've had other speakers talk on many different topics, but our collective agreement is between our employer and the members. We have a unique situation where our employer has work for us and we promise we will do that work for a set wage. When that agreement between the employer and the employees is threatened in any way, it creates a certain amount of stress for our employees. To have our wages possibly tampered with, and our benefits as well—these are the things that are crucial to every single employee and the jobs we do in the hospital. Everybody needs to earn a fair wage. With our wages we look after our families, we look after the food, water, clothing and shelter that we all need to survive in this country. And if anything does happen to us at work, we also need our benefits, our dental plans, to be protected. With the interpretations of Bill 8 that we have before us, as far as a CUPE local, we find that our collective agreements might be in jeopardy.

1340

With the stress that has gone around our hospital in the last couple of weeks, I don't find that our employees are able to focus on their jobs. They're thinking so much about the possibilities of having our wages rolled back and our benefits decreased. This, I find, to be very pertinent, because it will reflect totally on our patient care. When we go to the hospital, our minds should be focused

on our patients. Whether it is the clerical staff we provide, whether it's the RPNs or the paramedic services, we need our staff to focus on their jobs; even our housekeeping staff, who I believe strongly have one of the most important roles in our hospitals. We need every single employee to be focused on their jobs. The only way we can take that stress away from them is to assure them that our collective agreements are going to be intact. Whether they are current or upcoming collective agreements, nobody has the right to come in and start to dismantle them. All we are asking for as hospital workers is fair wages for fair work.

I'll go back to an example of our housekeeping staff. As the rumours around our hospital have been filtering for the last two weeks, if our housekeeping staff in the hospital have their wages decreased, we know there will be a large influx of employees coming into the hospital, temporarily working for a little while until they find employment elsewhere, and then leaving the hospital setting. We know that if the wages are rolled back in a very crucial sector—housekeeping—I'm not saying they're going to do a lesser job, but they might not be inclined to be as dedicated to their job as I can attest the housekeeping staff we have at North Bay General Hospital are.

In the last couple of years we've seen a lot of different things arise in the hospital. Last year we dealt with SARS. This year we're dealing with influenza, as we have in other years as well. With these outbreaks, with the fear of SARS that hit Ontario last year, especially in the Toronto region, I find it is our housekeepers who are at the front line of fighting this. They are on the front line of defeating that disease that was going around in our province. It's the same with the influenza outbreaks we are having to deal with in our hospitals. Our housekeeping staff are the front-line people, and if they don't do their jobs properly, it's going to be very difficult for our nurses, our doctors and our paramedics to do their jobs as well. If disease runs rampant in our hospital because our housekeeping staff has had their wages rolled back, we find that is also going to affect patient care in the province and in the rest of our hospitals.

It's interesting; on the shirts of some of the members who have travelled with me over 100 kilometres this afternoon to attend this presentation before the standing committee it says "CUPE: We are the Canadian Union of Public Employees." And there's a little line after that which says "On the front line." This is something that struck me on the way up here, as I was watching the members with these shirts on. It's absolutely right. When CUPE put that line in there, on a lot of our letterheads and on our T-shirts, they were exactly right: We are the front-line workers. We are the ones who are dealing with SARS, we are the ones who are dealing with influenza on a daily basis, and it is because of us that we are winning the battles in a lot of these areas in our hospital.

How important is it to have a collective agreement in a workforce? Our collective agreements are so important to us. They give us the security of knowing we're going to

work tomorrow, we have a safe workplace to work in, we have wages that are acceptable for the work and we can provide for our families. The collective agreements give us the security to do a job that we have to do in the hospital.

As a paramedic, the last thing that I need to worry about on a daily basis is whether a bill that may come into play in Ontario, like Bill 8, may threaten my wages. That's the last thing I need to worry about. We go on calls on a daily basis, and what we find is that we have to concentrate 100% on our patient care. We have to focus strictly on the patient that we have before us and give them the proper treatment and care that they are due in this province. I'm so proud to live in a province like Ontario, because I've not seen any other in Canada like this one.

Paramedics and training: This is what we have to concentrate on as paramedics, future training to improve our skills so that we can provide better care for the people and the public of Ontario. The last thing we need as paramedics is to be concentrating on the possibility of our collective agreement being dismantled, whether it is the current ones that we have or any upcoming collective agreements that we are negotiating in the future.

Why are hospital workers so up in arms? I have the pleasure of being the president of this local. I know quite a few of them, and I talk to them on a daily basis. Just recently, I divulged to them at a membership meeting a secret that I never had told them before, and that was, as I travel around the hospital from floor to floor—in the emergency department, X-ray, CAT scan—I watch my members work on a daily basis. I am so proud of the 530 members that I have in my local because of the job they do. When they're there every day, they know that I am here to protect their collective agreement as the president, and they know that, at the end of the week, they have a fair wage to take home and their benefits are still intact. These workers are very, very confident in doing their job because there is no worry, there is no threat at that time to their collective agreements.

With the introduction of Bill 8, I can tell you that in the last couple of weeks the stress in our hospital has increased dramatically. Everybody is worried about wages being rolled back, and they're not concentrating on their jobs. I can see it on their faces every single day. I can see it with the paramedics I work with, and I can see it in every aspect that CUPE provides employees for at North Bay General Hospital. I find that such a simple thing as an agreement between an employer and an employee has so much effect on the people; it does.

I urge you strongly that the amendments that we are seeking today—I have provided a brief before you today—are to go back to the government and tell them that CUPE in North Bay and in Ontario wants to protect its collective agreements. This is a very important thing for the workers. We are not very highly paid. Some of us in different sectors of the hospital have different wage grids, but we are very much affected if we are having our wages cut back. This is something that I wish to relieve

the stress on our workers so they can get back to the job of fighting influenza, SARS, if it ever hits back, or anything else that comes up in the future. A lot of the Web sites that I've been visiting lately are showing that there is evidence of different diseases that are coming out into the public.

We need to have our housekeeping staff, just for an example, not going to work worrying about their wages. We need them to go to work and worry about the cleaning that they do. It is absolutely amazing to see these people at work. They have such pride in their jobs. Another word that CUPE often uses in its literature is pride—pride to be in the union, but I've looked at that word "pride" and taken it to be the pride in their jobs.

1350

I don't think we are asking for the government to throw this bill right out of the House. I think the amendments we have put forward are reasonable. I believe strongly in preserving this collective agreement for all of the workers in Ontario and all of the hospitals.

The freedoms that we have in this province are to find work, and work in a safe environment, so that we can provide for our families. The threat that has come to us recently with Bill 8 and the concerns we have for it—I emphasize strongly the amount of stress that it has put on my workers. I myself have taken that stress, but I've taken on the position as president of this local to also try to ease their fears and to take that fear and the energy that is involved in it and direct it in a direction to do something about Bill 8, and not just sit back and be fearful of it. I have tried recently at some general membership meetings to encourage them to let go of the fear and to focus our energies on just making some changes to the bill, because we are not opposed to the bill in whole. We would like to see some amendments to it that would give our workers the security again that they're looking for.

I will be very brief and close with a simple example that was presented to me once. There was a master, a teacher, and a student. This student tried so hard to catch his master in any sort of mistake. He tried for years and years to do it. The master, as the teacher, was quite aware that the student was trying to do this. One day the student thought, "OK, I think I've got him on this one." He had a small bird, and he put it in his hand. He put his hands behind his back and he asked his teacher to guess which hand he had the bird in. The teacher, being wise, having many years of learned experience, knew that the student was trying to catch him again with some sort of trickery. The teacher replied to the student, "Well, I don't know exactly what hand it is, but the answer is in your hands."

I say to you, as a standing committee, please go back to our government and tell them that the hospital workers want their security. The hospital workers are the front-line people in many diseases that are arising in this province, and the bird is in your hands, as a standing committee, to go back to our government and plead our case to them that we just want our collective agreement preserved, and consider the amendments that we have put forward before you.

I thank you for the time that you've given me to speak here. I thank you on behalf of the 530 members of CUPE local 139 and North Bay General Hospital.

The Chair: Thank you, Mr Kotsopoulos. We're going to start with Ms Martel.

Ms Martel: Thanks, Bill, for coming here today, and thanks to your members as well who came with you, took the time to drive here to participate in this process.

Let me begin with the concerns you've raised with respect to collective agreements and the sections in the bill that the legal opinion that was done identified as being of particular concern to health care workers.

Yesterday, the minister in the committee said, "Bill 8 can't open collective agreements and unions have never been subject to accountability agreements, but we've agreed to make that more explicit." He told the committee that some wording to that effect, potential amendments, would be provided to the committee—we hope, sooner than later. We don't have that yet so we're operating in a bit of a vacuum in terms of what the government is actually going to propose. It is helpful that you have reiterated some of the proposed wording that could relieve members of their concern with respect to collective agreements, and we saw the language earlier in a presentation by Joanne Arnold, who also represents CUPE hospital workers here in Sudbury. So I appreciate that you've reiterated that.

One of the questions I had, though, was the amendments that you've proposed very specifically relate to collective agreements, and I understand why. But there's another section in the bill that I think could also be used, without even dealing with collective agreements, that could impact on your members. This has to do with the compliance directives. The compliance directives, section 22 in the bill, make it really clear that, "The minister may at any time issue a directive compelling a health resource provider or any other prescribed person, agency or entity to take or to refrain from taking any action that is specified in the directive or to comply with one or more of the prescribed compliance measures."

Taken to its extreme, perhaps, some would argue, a minister could then decide that he wants to amalgamate food services or amalgamate laundry services or contract out food services or contract out laundry services in a hospital and could certainly compel an agency or an entity, a hospital board, to do that, as the language currently stands. Is that of concern to you and could CUPE also bring forward amendments or recommendations about how to deal with that section, which doesn't say anything about collective agreements but could be just as damaging to your members if they lose their jobs through the privatization of positions that you now hold?

Mr Kotsopoulos: Absolutely. Thank you for the question, Ms Martel. Absolutely. There were so many different aspects of this bill that I could have spoken on this afternoon. I was just taking the concern from our membership meetings, and that was centralized on the collective agreement. But absolutely; we have a very deep concern about the compliance directives and the

possibility of privatization. I've been very active in our community about informing the public about any sort of privatization, P3 hospitals, contracting out. We believe that the language that we can negotiate in the future, as well as the current language in our collective agreement, can preserve our jobs, that no employer has the ability to go out and contract some of these services that you had mentioned, yes.

Ms Martel: It's going to depend on whether or not a minister's orders or directives would override a collective agreement, and that's not spelled out. It's not referenced one way or the other. The legislation is silent. You could, and you would as a good trade union president, do everything you can in that regard, except that if a minister's compliance directives overrode the collective agreement and the minister was intent on consolidating services or contracting out, no matter what you did as the union president, no matter what was in the collective agreement, that could still be lost. That's another concern that I have. The legislation is silent on what prevails in terms of directives over collective agreements. I think that section is going to have to be dealt with as well.

You also talked about privatization, and I appreciated that you—

The Chair: Could you summarize, please, Ms Martel?

Ms Martel: You quoted the minister by saying, "We are slamming the door shut on two-tier, pay-your-way-to-the-front-of-the-line health care in Ontario." If the government doesn't stop the P3 hospitals, and they haven't, and if the government doesn't shut down the private MRI and CAT scan clinics and move that technology into public hospitals, do you really think the government is slamming the door on further two-tier private health care?

Mr Kotsopoulos: To answer the first part of that, the sweeping powers of the Minister of Health are a very great concern to us. We worry about the possibilities of the minister making such a directive and coming in and pretty much dismantling our collective agreement. We are very concerned about the sweeping powers that the minister may have. I agree with you. During the election there were a lot of promises about MRIs and CAT scans and saying no to P3 hospitals, but we haven't heard any sort of direction from this government at this time that they will not and stop that direction.

1400

The Chair: Ms Smith, did you want to lead off? I've also got Mr Duguid and Mr Delaney, and we've got four minutes.

Ms Smith: I will just say that I want to apologize to Bill that I didn't get here for the beginning of your presentation. I apologize.

Mr Kotsopoulos: That's OK.

Ms Smith: I got caught up in an long-term-care issue that I'm also working on. But we will get to chat, I'm sure, many times because Bill and I live in the same town, and I know a lot of his workers. I have received e-mails and lots of concern from your workers on the collective agreement issue.

Let me just say—and I'm going to pass this on to my colleagues—that in his statement yesterday the minister made it very clear that this bill does not apply to collective agreements, nor would accountability agreements apply to trade unions. I'll give you a copy of his statement so you have that. I don't believe that collective agreements or your workers are at risk from anything in this bill. If anything, we're protecting medicare, we're protecting publicly funded medicare for all citizens of Ontario, and that will apply to all of your workers.

Let me just pass on to my co-workers. I'm happy to continue the conversation with you at home.

Mr Kotsopoulos: Absolutely. Thank you. I can do this whole presentation for you again in North Bay.

The Chair: You lucky woman. Mr Duguid.

Mr Duguid: Mr Kotsopoulos, I want to thank you for coming here today as well, and for your passion that you've shown us for the concern for the employees that you represent.

You talked about stress. I think it's being felt through the entire health care system. I've got a sister who's a nurse in North York. She was on the SARS unit the entire time, and I can tell you, everybody in those institutions is feeling stress right now and it's still a factor of burnout from that SARS scare.

I'm going to read to you, though, a letter that was written by the minister to Sid Ryan, just very quickly in the few seconds I have left to help clarify to you and maybe put you at ease in terms of the government's intentions.

It says: "Dear Mr Ryan,

"I am extremely troubled by recent statements from CUPE that Bill 8, the Commitment to the Future of Medicare Act, will allow for opening collective agreements and threaten the job security and livelihood of Ontario workers. This is patently untrue.

"Here are the facts, the same facts that I told you during our meeting on January 13.

"The intent of Bill 8 is that accountability agreements are established only with board of directors of publicly funded health care institutions. Labour unions are not subject to and will never be subject to accountability agreements. Bill 8 cannot open collective agreements. You know this, because I told you that when we met. In fact, during our meeting I conveyed our openness to explicitly state in the bill that labour unions are not subject to the legislation.

"Further, collective agreements are protected by various pieces of legislation in Ontario. Bill 8 will not reduce that protection."

I understand the concerns that were raised. I understand why there were some people who were questioning certain parts of the bill. I guess my question to you is, now that you've been given this information, and given that Mr Ryan had this information as of January 13, will you endeavour to make sure that your members are made aware of our intentions, so that the stressful environment they're already operating in can be eased somewhat?

Mr Kotsopoulos: Absolutely. I would love to go back home to North Bay and have another meeting and relieve

their stress, as much as I tried the other day at a general membership meeting. I know that there is an informal draft coming up very soon—I think on Thursday of this week. I note that there is a final draft March 9 of the amendments to Bill 8 that are going to be presented by the minister. I think when I can actually see something concrete that spells out very, very clearly, with all sorts of interpretations from the legal firms and from the public as well, at that point I can go to my members and tell them to get back to the job of looking after patients and the hospital, which I'm still trying to do now. But I want to give them 100% assurance. I think when we see something final, at that time I can really do it and do a better job.

The Chair: Unfortunately, the time has expired for the government side. We will have to put you on next.

Mr Delaney: My points had already been made, so I'm done.

The Chair: That makes life easier. Mr Wilson, four minutes.

Mr Wilson: Yes, I've been on the side of the government where your time expires. Believe me. That's why I'm on this side now.

Bill, you did a great job, as Joanne Arnold and Michael Hurley did before you, in terms of, I don't find myself very often in my 14-year career agreeing with the labour movement on too many points of law.

Ms Martel: That's true; that's true.

Mr Wilson: That's why I have the largest plurality in Canadian history.

Having said that, I do respect the points you make. Here's the point I'd like to make, and that is that unless you get rid of the whole accountability agreements and compliance directives—Ms Martel was bang on in her comments—I don't know how it can't affect your membership. For instance, if a compliance directive says, "The CEO, or the board, shall come within budget this year," and we heard evidence today that local hospitals—\$7 million. I know from three years as health minister that it's always been over budget. In the past it was always moral suasion. As awful as it was playing out in the media and the pickets and everything, the minister never had a compliance directive that said, "You shall be fined \$100,000 if you don't go my way."

I had to go into those hospital boards; I had to take the crap from the media, the unions and everyone else. It's all part of the democratic process. I sign up for it. I ask 100,000 voters in my riding every four or five years to put me through this again, so I can go out there. But it was moral suasion. This is the first time in the history of health legislation, outside of public health legislation—you, as a paramedic, know that sometimes a medical officer of health has to give a directive and it has to be followed. This is the first time a minister has said, "You shall do X." If, for example, the compliance agreement says, "You shall balance your budget," and that means laying off 30 or 40 people, then it affects your members.

Mr Kotsopoulos: Absolutely.

Mr Wilson: I just want you to take back that we're going to do our best—Mr Klees moved a motion earlier

today with Joanne Arnold's wording—because I don't think that's right. I think part of asking people to vote for you and part of being an MPP is to get beat up once in a while, to have to go in and argue and then come out and explain to the media and the public what you've agreed upon.

The Chair: Thank you, Mr Kotsopoulos. We appreciate your presence here today and your input.

SUDBURY AND DISTRICT LABOUR COUNCIL

The Chair: We'll now move on to the next delegation this afternoon, the Sudbury and District Labour Council: Alexander Bass, president, and John Filo, past president. Is that right? You know what the rules are.

Mr John Filo: This is Alexander Bass, or Sandy Bass, as he is affectionately known, and I'm John Filo. I want to welcome this committee to Sudbury. Bienvenue à Sudbury, and for my Lebanese colleague:

Remarks in Lebanese.

I see he's out of the room at this moment.

The Chair: You've got to say that again. He'll be impressed.

Mr Delaney: On his behalf, then:

Remarks in Lebanese.

Mr Filo: The Sudbury and District Labour Council represents 15,000 unionized individuals in greater Sudbury and the surrounding area. We represent a myriad of occupations, from custodial staff to university and college professors, assorted trades, professional government workers and of course a great variety of health care workers.

Incidentally, in welcoming this committee to Sudbury, I forgot to mention that I missed the reception committee: all the pickets and the Ontario Provincial Police security phalanx that we had under the previous government.

To say we are deeply concerned that the present Liberal government will deal with medicare in a pragmatic manner that benefits the entire population of Ontario is an understatement. Basically, we want honesty, decency and fairness, and we feel that we're getting spin, glibness and semantics. Our own Sudbury MPP, for example—and I'm sorry that Rick isn't here to defend himself—so vocal when in opposition in prodding the Tory government to rectify the problems with our regional hospital, has become an apologist for his colleagues, citing the bogeyman of the unexpected deficit that the Eves team imposed on the province. Didn't anyone listen to Gerry Phillips or the Fraser Institute, whose report was authored by an individual close to the Harris-Eves government?

Even the title of this bill is reminiscent of the way in which the previous government labelled their bills. The label often was the most progressive and positive aspect of the bill, while the body of the bill sought to accomplish the diametric opposite, as in some ways Bill 8 does.

I want to comment that I heard the words from Monique Smith accusing Hurley of misleading people. Do I have to remind you about the Oak Ridges moraine

or Highway 407? One of your colleagues read a letter from Sid Ryan. I can read from Hansard, I can read from your program, from your platform: You are the ones who misled.

1410

Democracy in Canada and Ontario works well when systems are implemented that are characterized by openness, transparency and accountability, and corporate privacy issues are subservient to the right to know of the citizens and taxpayers who pick up the tab. Checks and balances are necessary, though not often sufficient to prevent fiascos such as those plaguing the federal Liberals. What, then, is the rationale for conferring on the minister the power to direct any health resource provider, person, agency or entity, which may include unions, to enter into accountability agreements with the minister? Further, such wide-ranging powers are being bestowed on the minister in other areas of the bill that are too all-encompassing and ill-defined, thus allowing the minister to play fast and loose with the content and the target populations to which they may be directed.

The labour movement is categorically opposed to the privatization of any component of our health care system, because it's a device to reduce the role of government by spouting the propaganda that private enterprise is more efficient and desirable, whereas public services are costly, inefficient and undesirable. The real motive, however, is to allow favoured groups to generate profits at the expense of no-income and low- and middle-income people. We know that the easily treated medical problems, the ones with high profit margins, are the ones that get privatized, while the costly and intractable problems are left in the public sphere, making the cost much higher there. The siren song of lower taxes and less government has its appeal, but in a closed economic system, the expenditures have to be transferred somewhere. Privatization ensures that costs are directed from those most able to pay to those least able.

Private enterprise, in a holier-than-thou gloating, is quick to use examples such as the sponsorship scandal in Quebec to trumpet the advantages of the private route. To place in perspective the revulsion we experience when it is revealed that hundreds of millions of dollars are channelled by a government to a privileged few, we have to recognize that the resources that private enterprise—as represented by Enron, Tyco, Nortel and the dot.com multinationals—squandered amounted to trillions of dollars, four orders of magnitude higher. Ask any senior who invested in mutual funds for a retirement benefit how the investment has fared over the past few years because of private enterprise efficiency. In the end, it must be emphasized that it was the private sector that benefited from the corrupt misuse of moneys in the Quebec example.

John Kenneth Galbraith said that right-wing economists, who we believe are inordinately influencing this Liberal government, believe that the poor have too much money and the rich too little. The modern neo-liberal, he alleged, is engaged in one of man's oldest exercises in

moral philosophy: the search for a superior moral justification for selfishness. As a commentary, we will track very closely this Liberal government to see which of its left-wing promises and which of its right-wing promises it's going to keep. We suspect the left-wing promises are going to be shelved and the right-wing promises are the ones they're going to subscribe to.

If, as mentioned in the preamble, catastrophic drug costs and primary health care based on assessed needs are central to the future of medicare, please drop the other shoe and deal with this shortcoming in a revised bill.

Successive governments in the past have used their surgical skills in delisting services and procedures, not only to reduce costs but also to facilitate the burgeoning expansion of the two-tier model of health care for uninsured measures. How cleverly has the private sector taken advantage of this subtle progression, until now we have the inexplicable prohibition of queue-jumping for medically necessary services but not for medically delisted services. This is broken. Design legislation to fix it.

Are we going to have the Ontario Health Quality Council peopled with lackeys to the present government, paralleling the model established by Harris and Eves? Locally, we had independent, community-minded persons removed from agencies, boards and commissions and replaced by card-carrying ideologues, some of whom performed their duties without regard to the impact on the community, but toadied up to the powers that be.

User and/or block fees create barriers to access. These must not be allowed through regulation or in a revised bill.

Our friend Jim Wilson noted that union dues have to be paid by people working in a particular industry, and asked why doctors shouldn't charge block fees. That's like comparing apples and oranges. You see, doctors pay fees, professional engineers pay fees and lawyers pay fees to practise their professions. Those are income-earning entities. A patient doesn't go to a doctor to earn an income, Mr Wilson, so you're way off on your analogy there.

I regret that my presentation has provided little detail concerning some of the other parts of the bill that we have serious problems with, but I am confident that ONA, unions such as OPSEU and CUPE, and the Ontario Health Coalition will amplify the concerns with this very flawed legislation.

Remarks in Lebanese.

The Chair: I'm not sure if we have a Lebanese translator. You've used up about eight minutes of your time, which leaves us with seven minutes each for questions, starting with the government side.

Do you want to go first, Ms Smith, or do you want to pass it on to Mr Delaney?

Ms Smith: I'll start and then pass it on.

I just wanted to address some of the concerns you raised about your Sudbury MPP. I think the fact that the Minister of Health was able to visit this community within three months of taking office and, together with your local member, Mr Bartolucci, is planning a summit

to deal with the log-jam that has built up with respect to your regional health facility, would indicate that your member is diligently working on your behalf. I believe that all in northeastern Ontario will see some movement on that in the near future. I would just note there is movement; that is coming in. Certainly, problems that have built up over the last five years are being addressed in short order.

I note in the second paragraph of your presentation that you talk about openness, transparency and accountability. Those are all themes that run through Bill 8, and I think we do have common ground on that. You also talk about the necessity of checks and balances, and that is exactly what we're looking for in implementing accountability agreements between health care providers or health care institutions and the Ministry of Health. I wonder how you feel that an accountability agreement would not provide some checks and balances between these institutions and the ministry.

Mr Filo: Let me go back to the first part of your answer about Mr Bartolucci and that he's doing this and that. It's what we call in the gambling profession "all on the if-come." This is what he said in Hansard: "We demand that you send the cheque and get the project on board again." That doesn't mean tomorrow or the next day or the next month. Sure, he's got some plans, but they're in the future and they're indefinite.

The other point you make about checks and balances: Somebody like Saddam Hussein or George W. Bush would be pleased with the powers you're conferring on the minister. There are no checks and balances there.

Mr Smitherman is a rational, reasonably decent person, but eventually you'll get somebody in there who won't have the same perspective he has, and he then has autocratic power. There are no checks and balances there. Can't you see that, Monique?

Ms Smith: I don't see it the same way you do. I do appreciate that you see our minister as being reasonable.

We intend to bring amendments to this legislation, and I think you've been here through some of this morning's presentations and heard us talk about the fact that we're bringing in amendments to add some flesh to the bones. We did note that this was brought out after first reading and that we were open to much consultation. That's why we're here; that's why we're travelling the province. So we do intend to bring more heft to the provisions you're talking about, and certainly some safeguards so that the concerns you've raised with respect to unfettered discretion will be addressed.

I did want to ask you a question just before I pass on to one of my colleagues. You spoke about the health quality council and your concerns about the membership. What would you propose as being an appropriate membership for that council?

Mr Filo: It's been proposed already. Something democratically elected, representation from various sectors and so on. I'm not here to write the regulations, but the staff that you have, with the resources that are at your disposal, can surely see that's the way to do it, rather than by appointment.

1420

Ms Smith: Thank you for your input. I think one of my colleagues has a question.

The Chair: Mr Delaney, do you have a question, or Mr Duguid?

Mr Delaney: I just have a point that was brought up here, more in the way of clarification. At the moment, Ontario has no defined way of knowing whether health care dollars are currently being spent wisely. The auditor can count up how much is being spent, but this bill is a way in which we can place a value judgment on how well the money allocated to health is being spent. The Commitment to the Future of Medicare Act, 2003, if passed, would create an innovative way of doing just that, which is the Ontario Health Quality Council. This health quality council and the other measures in this bill in fact toughen prohibitions against two-tier medicine and they enhance health sector accountability. That is their intent. The proposed act, in fact, would close down various loopholes that may result in extra-billing and in user fees and enhance the ability of the Ontario public to monitor and to enforce such a provision. Finally, a lot of what's in Bill 8 is about establishing new accountability frameworks with our health care partners that demonstrate to the public—and that's the key part, to demonstrate to the public—that they're receiving value for the money expended on health care. Was there any specific provision that you wanted to raise a specific point on?

Mr Filo: I thought I did. It's the appointment of the members to the health council. Sure, all the provisions and the mandate of the council are motherhood and apple pie, but if you appoint people who are going to toe the party line and not give you a view that's representative of the community, how much worth is that?

Mr Delaney: I posed several such questions yesterday to the Minister of Health, and I think, as you see, the drafts of the bill continue to evolve. I'm hopeful that the questions that I posed and some of the ones you've raised will be answered.

Mr Filo: Can I respond to that, Mr Chair?

The Chair: Very briefly. We've got about 10 seconds.

Mr Filo: To me, the symptom of flawed legislation is the very fact that you have to introduce so many amendments. Was this bill written on the back of an envelope? Was this guy you brought in from BC the one who sketched it out for you? Don't forget that if the legislation is well focused and well prepared, amendments would be minimal. Here you have to make many, many amendments to address the shortcomings.

Mr Klees: Thank you very much for your presentation. In fact, the question you just asked is one I've been asking for the last couple of days, although not in those words. But how we could come to the point where the Ministry of Health, with all of its resources, very well-paid people in the policy department, people who have been drafting and recommending legislation for years as a profession, could end up handing to the minister a piece of legislation such as we have before us—

Mr Filo: Junk.

Mr Klees: —is beyond me, although it's not beyond me, because I don't for a minute, as I don't believe you do, believe that the minister was not aware of what this legislation says, that those who put it forward for first reading were not fully aware of the powers that it was in fact conferring upon the minister, the incredible implications that it has, not only to labour unions' collective agreements but for every stakeholder and every health care worker in the entire health care field. What does confound me is that they thought they could get away with it. But as we're seeing from all of the representations, they can't. But what they are facing now is a problem of such a flawed piece of legislation that it won't be recognizable if they in fact do all the things that are being recommended and that they're already agreeing to. I've made a suggestion: I think the parliamentary assistant should take it upon herself to make a phone call to the minister this afternoon and say, "Look, let's not waste anyone else's time here. Let's withdraw this legislation. Let's start over, and let's really look at the principles we've set out in the preamble"—which are laudable—"and get to work and craft something that really does reflect our intentions." Would you agree with that?

Mr Filo: Of course.

Mr Klees: Would you make that recommendation to the parliamentary assistant?

Mr Filo: I'd be pleased to make that recommendation. Monique Smith, please go back to your cabinet and recommend to them that they scrap this bill and start anew on the basis of the consultations you've held across the province. Furthermore, the motion that was moved by Frank Klees—I would expect that one of the members of the government would be the first person to move a similar type of motion once these hearings are over.

Ms Smith: Mr Chair, I can assure the presenter that we will be looking at that type of amendment. The minister stated that in his presentation yesterday. We've stated it during pretty much every presentation today. It's pretty clear that we will be doing that. I thank the presenter and Mr Klees for the recommendation. It's unfortunate that Mr Klees does not want to travel the province and get input from the citizens of Ontario on this legislation, which we think is important, and that's what we're doing. We'll continue to do that, and we'll come back to you.

Mr Duguid: That was just not their style. They're not used to it.

Ms Smith: I know consultation is not your forte, but we'll continue.

The Chair: Your time has not expired, Mr Klees. You still have more time. You had the floor. You did invite that exchange, but you still have time left.

Mr Klees: I did, and I'm happy that we've got some time. I don't need to be lectured to about consultation. I know full well about consultation. One of the best consultations Ontario has is an election. Let me remind members opposite and everyone who is listening that

there were very specific commitments made by the Liberal Party and by Mr McGuinty during that very broad consultation. I would expect that at least some of that consultation that people voted very strongly—a lot of my colleagues aren't here. We got voted out of office based on that consultation and those promises that were made by the Liberal Party. How about keeping some of those commitments? What you're doing now with this legislation is an about-face on those fundamental consultations. Why should anyone waste their time coming forward and consulting with you when you didn't keep your promises on the first consultation? That's my question to you.

Ms Smith: To the presenter?

Mr Klees: It's to you, not to the presenter. The presenter knows full well that your credibility is very quickly eroding in this province.

The Chair: OK. We have a gentleman sitting at the end of the table who has been kind enough to make presentations to us.

Mr Klees: I can use my time in any way I choose.

The Chair: That's what I'm saying. The cross debate between the members perhaps should—

Mr Filo: I appreciate the question, Mr Klees, whether I agree with your statements or not. I have to say that, by and large, I agree wholeheartedly with the points you've made. I think I'm a little old-fashioned, but I think morality and ethics have a place in the community and that nobody should make promises lightly. I know that once in a while you make a promise and you can't live up to it and you have to do some sort of penance for that. You can't make promises and then say, "Well, look, sorry. That was then, this is now."

The Chair: Thank you, Mr Klees. Ms Martel, seven minutes.

Ms Martel: Thanks, John and Sandy, for coming today. I think it's worth putting on the record some of the powers the minister has, because in point of fact, although there has been some discussion about amendments, it was not terribly clear to which sections and what kinds of changes were coming forward, with the exception of a promise that collective agreements would not be eroded. The minister has very broad powers, which I think people need to think about again.

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Compliance directives, section 22: "The minister may at any time issue a directive compelling a health resource provider or any other prescribed person, agency or entity to take or to refrain from taking any action that is specified in the directive or to comply with one or more of the prescribed compliance measures."

Subsection 22(2): "In any directive under this section, the minister may specify the time or times when or the period or periods of time within which the health resource provider or any other prescribed person, agency or entity to whom the directive is issued must comply with the directive."

Look at section 24, termination: "The minister may at any time terminate an accountability agreement or a com-

pliance directive, and may at any time vary a compliance directive or issue a new compliance directive."

Section 26: "Where, in the opinion of the minister, any person, agency or entity described in section 21 or 22 fails to enter into an accountability agreement, fails to comply with any terms of an accountability agreement or fails to comply with all or any part of a compliance directive, the minister may make an order providing for one or more prescribed measures."

Those are just four examples in the accountability agreement section of the very broad powers of the minister. We have no clear sense of how those broad powers are going to be curbed. John, may I ask you, why are you worried, as you listen to this language, about the very broad, perhaps unwieldy, powers of the minister?

Mr Filo: Because not even my wife has those powers in my household. I mean, my children do, but my wife doesn't. It's too much. It's too indefinite. It's too vague. A person who has an unscrupulous bent can do it to advance an agenda that's contrary to the community interests.

Ms Martel: You talked about the preamble. You said, "If, as mentioned in the preamble, catastrophic drug costs and primary health care based on assessed need are central to the future of medicare, drop the other shoe and in a revised bill deal with the shortcoming." I'm assuming you mean in a revised bill bring forward some actual provisions that put this into place. I'll just give you a couple of examples.

The preamble talks about pharmacare. There is no other reference to pharmacare. The preamble talks about home care. There is no other reference to home care in the bill; certainly not a provision to end competitive bidding, for example, in home care. The preamble talks about the prohibition of user fees, while at the same time the government is musing very publicly about a means test for seniors for Ontario drug benefits, which would result in user fees for many seniors if they are above the income test. Is that what you mean, that maybe the government should get past the rhetoric in the preamble and get to some detailed provisions in the bill which put some of this into effect?

Mr Filo: Exactly, Ms Martel. If you look at the costs that are involved with these miracle drugs that they're putting on the market, I think there's a saving of millions—no, not millions of dollars; tens or hundreds of millions of dollars—to the health care sector if somehow or other the cost of those drugs were brought under control and if there were a public method of distribution devised so that the cost to the individual would be nothing because it would be paid through their taxes and the cost to the system would be minimized.

Ms Martel: I wanted to just talk about the functions of the council, because I questioned the minister about this yesterday. My concern with respect to the council is that it appears to be a council that will primarily do monitoring and reporting. Monitoring and reporting on health outcomes are fine, but if there's no mechanism to force the minister to respond to the reports and the

outcomes, then there is no accountability. The minister tried to say yesterday that this council is an accountability mechanism that's going to force him to do something. Well, no, it's not, because all they can do is report and monitor. They can't even make recommendations about how money can be spent. Can you give me a sense of how effective, in terms of really dealing with health care policy and the changes that have to be made, a council will be that can only essentially monitor and report and not make any recommendation for change, either to legislation, to health care policy, to funding or to even dealing with the results of the outcomes they're reporting on.

Mr Filo: The federal ethics councillor, Mr Wilson, had real teeth when he had his judgments vetted by Chrétien concerning Chrétien's double dealing. If the health council is appointed and is staffed by people who are sympathetic to the government, will do exactly the same thing. They won't even recommend. So we need something similar to what the Auditor General does in the federal government, where they make a statement, they have resources where they do significant cost-effective audits, and they present the report to the Parliament—to the Legislative Assembly in Toronto—and the government is forced to act on it.

Ms Martel: So they do have the power for recommendations. Because if you look, the only power this council has about recommendations appears in subsection (4). It says, "(4) In a report under this section the council may make recommendations to the minister but only in regard to future areas of reporting."

Mr Filo: I've been in the union movement for 30 years, and a word like "may" has absolutely no impact. Words have to be like "must" or—

Ms Martel: "Shall."

Mr Filo: It has to be mandatory rather than permissive.

The Chair: Thank you, gentlemen. We appreciate your coming forward.

ASSOCIATION DES TRAVAILLEUSES
ET TRAVAILLEURS SOCIAUX
DE L'ONTARIO,
CHAPITRE DE SUDBURY
ONTARIO ASSOCIATION
OF SOCIAL WORKERS,
SUDBURY BRANCH

The Chair: Our next speaker is from the Ontario Association of Social Workers, Sudbury branch: Marie Turcotte, who I understand will be addressing us in French. You have 30 minutes, Ms Turcotte. You can use that any way you like. At the end of the 30 minutes we will split any time remaining among all three parties to ask you questions. The floor is yours.

Mme Marie Turcotte: Je fais partie de l'exécutif provincial de l'Association des travailleurs sociaux. Nous sommes incorporés depuis 1964. Nous sommes un peu

plus de 3 000 membres répartis dans 15 chapitres à travers la province. Tous les membres ont un degré universitaire en service social. Vous trouverez ci-joint le texte de la présentation en anglais, mais ce que je vais donner en français, c'est plutôt un résumé, puis je vais souligner les points importants.

Premièrement, nous voulons féliciter le gouvernement de vouloir inscrire dans ce projet de loi 8 l'universalité des soins de santé qui est déjà garantie dans la loi fédérale. Tout système à deux vitesses de santé contrevient à la loi fédérale. Nous trouvons que la Loi 8 telle qu'elle est présentée actuellement n'assure pas l'implantation des principes contenus dans la Loi canadienne sur la santé, et ne va pas améliorer le processus démocratique, la transparence puis la coresponsabilité dans le système de santé. Elle n'empêchera pas l'érosion du système par la privatisation et les corporations à but lucratif et le système de santé à deux niveaux.

Il va falloir plus que ce qui est écrit dans le préambule de la loi. Il va falloir des initiatives plus concrètes. En Ontario, on ne devrait pas allouer des cliniques privées offrant des « CT scans » et des « MRI » à des clients qui peuvent payer pour des tests non médicalement nécessaires alors que ceux qui ne peuvent pas payer ou qui ont des problèmes médicaux plus sévères doivent faire la queue dans le système public.

Dans les établissements de soins à long terme, 60 % des lits sont réservés pour ceux qui peuvent se payer une chambre privée ou semi-privée, réduisant ainsi l'accès à ceux qui ne peuvent pas payer ces taux. Dans ces mêmes établissements, des familles emploient parfois une personne pour donner des soins à leur parent parce qu'ils considèrent les services inadéquats. Alors, qu'arrive-t-il aux plus pauvres ? Risquent-ils de manquer des soins de base comme être lavés, nourris, changés à chaque jour ?

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Pour ce qui est des soins à domicile, encore là on n'en parle pas vraiment dans le bill. Depuis les coupures massives du temps des conservateurs, les services ont été réduits presque exclusivement aux soins personnels. Les services d'aide pour le ménage et l'épicerie ont presque été éliminés. L'accès à la physiothérapie, l'orthophonie, l'ergothérapie et les services sociaux ont été privatisés. Alors, les personnes en milieu rural ou dans les petites communautés ne peuvent pratiquement pas accéder à ces services. Des compagnies offrent ces services aux centres d'accès aux soins communautaires, mais pour réduire leurs coûts, ils emploient des personnes avec moins d'expérience ou avec moins de qualifications et qui ne sont pas prêtes à s'éloigner des grands centres pour aller offrir leurs services.

Nous supportons le fait que la Loi 8 ne permet pas aux médecins de se retirer de OHIP, mais la plupart d'entre eux facturent pour de plus en plus de services. Il est difficile de savoir si c'est légal ou pas. Juste pour avoir la liste des services que les médecins ont droit de facturer selon leur Ordre, il faut payer 100 \$.

Nous nous opposons à ces dépenses surnuméraires, aux « block fees », que certains médecins facturent une

fois l'an. Avec le peu de médecins disponibles, les patients seront peu portés à porter plainte ou à refuser de payer, de peur de ne plus avoir de médecin. Quelque 900 000 Ontariens n'ont pas accès à un médecin dans le moment, puis tous ceux qui déménagent à Sudbury, par exemple, ou dans d'autres villes de certaines régions savent qu'ils ne pourront pas trouver un autre médecin avant plusieurs années s'ils déménagent dans une autre localité.

La Loi 8 n'offre aucune garantie ou initiative concrète pour assurer les soins de santé de base à tous les Ontariens selon les principes de la loi canadienne; par exemple, pour les soins à domicile, les médicaments, les appareils pour la mobilité, et une liste de services couverts par OHIP qui devraient couvrir l'ensemble des services dont les gens ont besoin. Dans la dernière décennie, 100 \$ millions ont été éliminés en réduisant la liste des services assurables à travers OHIP.

Au sujet de la création d'un conseil pour évaluer la qualité des services de santé, les membres du conseil devraient être élus ou proposés par des groupes représentant les patients, les usagers des services et des experts, et non être nommés par le gouvernement. Il devrait comprendre des membres de toutes les régions géographiques de l'Ontario, même celles qui sont isolées. Aucune personne qui a des intérêts financiers dans le domaine de la santé ne devrait y siéger.

Ce conseil devrait pouvoir investiguer si le système de santé se conforme aux principes d'inclusion, d'accessibilité et d'universalité. Ceci comprend le système à deux niveaux, les frais pour les usagers et la facturation surnuméraire. Ce conseil devrait avoir le pouvoir de faire des recommandations et de conduire ces opérations de manière transparente pour le public.

Assurer un contrôle démocratique et de la transparence : nous craignons que la Loi 8 donne trop de pouvoir au ministre sur les individus et les organisations. Les ententes au sujet de la coresponsabilité fiscale devraient être établies conjointement avec les établissements et après consultation publique quand c'est possible pour éviter un contrôle autocratique de la part du gouvernement; par exemple, l'arrêt de la construction de l'hôpital régional ici depuis trois ans à partir de la décision d'un ministre.

Nous croyons que le système de santé est redévalable à tous les gens de la province et non seulement au ministre de manière pyramidale. Tout le système de santé devrait être régi de façon démocratique, avec des conseils d'administration élus, membre ouverte, possibilité de consultation et de représentants de groupes concernés, rapports financiers des hôpitaux ou des autres établissements de santé rendus publics, l'input des usagers et des employés du système de santé qui constatent des lacunes graves.

En conclusion, nous voulons dire qu'il faut arrêter l'établissement de corporations à but lucratif, de cliniques privées qui imposent des frais aux usagers et qui paient des salaires exorbitants à leurs administrateurs ou à leurs employés. Ils vont attirer les meilleurs

employés du système public dans leurs rangs et accroître encore plus la pénurie de personnel dans les établissements publics. Alors, plus de lits ou de départements devront être fermés. Les patients devront payer de plus en plus de services. Les frais de consultants et les frais légaux augmenteront.

Aussi, tous les hôpitaux de type P3 devraient être éliminés.

Les services non cliniques comme la nourriture, la buanderie, l'entretien ménager, les tests de laboratoire et les thérapies sont essentiels et doivent demeurer sur une base non lucrative.

Ce qui arrive souvent, c'est que les compagnies privées prennent leur clientèle parmi ceux qui sont couverts par les assurances privées ou le WSIB et ainsi ne permettent pas aux hôpitaux de retirer ces revenus, au détriment du système public de santé.

Le gouvernement libéral s'est compromis dans la campagne électorale à réduire la privatisation et la reconstruction du système medicare, et nous espérons qu'il gardera ses promesses. Merci.

The Chair: Thank you. The translation doesn't keep up with you. You finished before I finished listening. My apologies.

We do have about 20 minutes left. We're going to start this time with the Progressive Conservatives. You've got about six or seven minutes, Mr Wilson.

Mr Wilson: Thank you very much for your presentation.

You must have social workers, though, who work in public facilities and you must have social workers who work in private facilities, who do private consulting for school boards, for example, that sort of thing. Your comments dealt mainly with the public institutions, but do you have anything to say on behalf of those social workers who run a legitimate business, who are happy—I have two in my own family—working in a private setting, as you would say? I would just say it's another form of employment. I'm just wondering. I go back 14 years with your association and you never say anything about all those thousands of people who work in private settings.

M^{me} Turcotte: Disons que comme travailleurs sociaux on a vraiment à cœur l'intérêt des gens, surtout des plus pauvres, des classes les plus démunies. Actuellement, c'est à travers le système public où on voit que les droits de ces personnes sont plus négligés. Ceux qui peuvent se payer des services privés, il n'y a pas de problème là.

Mr Wilson: In terms of the public institutions, I've had the occasion, as I told the committee yesterday, to visit five hospitals in the last three months because of a sick friend and elderly parents, not just for a day but every day except two, and that's yesterday and today. The social work staff have been fantastic, very good. It's a young man who's dying. He actually works for the Ministry of Health and they've been very, very helpful. Those are major hospitals in Toronto. Do we have almost no staff in other hospitals throughout the north here, for

example? What's the status of social work in the hospital setting these days?

M^{me} Turcotte: De plus en plus, les postes de travailleurs sociaux sont menacés dans le système public. Dès qu'il y a des coupures, c'est souvent un des postes qui va partir. C'est dommage, parce qu'il y a vraiment un grand besoin pour toute l'intervention des travailleurs sociaux, surtout pour assurer le suivi lorsque la personne sort de l'hôpital puis qu'il n'y a pas de crise majeure dans la famille du côté de la santé mentale qui fait que la personne retourne à l'hôpital. Ça va coûter encore plus cher au système que si on avait pu assurer un suivi de ces personnes-là.

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Mr Wilson: It's too bad in one sense that you don't have a higher profile in our hospitals. At Mount Sinai Hospital in November, I guess because the social worker was so busy, the poor kid had to be there three weeks before he saw the social worker, but on the first day he saw the chaplaincy team. I'm not telling you something you don't know, but raising the profile of social workers, as you're doing today, isn't such a bad idea. I mean that sincerely.

M^{me} Turcotte: C'est une des priorités de l'association canadienne dans le moment. Je peux vous dire que je travaillais moi-même dans les soins à domicile avant, et dès qu'il y a eu la privatisation des services de thérapie à domicile—c'est très dommage, surtout pour le nord de l'Ontario. Ça ne s'applique pas juste aux travailleurs sociaux. C'est les physiothérapeutes, les ergothérapeutes etc. Les gens veulent mais ne peuvent plus se permettre d'aller dans les petites régions rurales éloignées parce que ça ne rapporte pas à l'agence qui les engage. Alors, il y a toute une population laissée-pour-compte.

The Chair: Thank you, Mr Wilson. Ms Martel?

M^{me} Martel: Merci d'être venue cet après-midi. Je l'apprécie beaucoup.

Je voudrais parler de la santé à but lucratif. C'est bien clair que le Parti libéral avait dit clairement avant les élections, premièrement, qu'ils allaient terminer tous les hôpitaux privés, et, deuxièmement, qu'ils allaient aussi annuler tous les contrats pour les CT scans-MRIs, les cliniques privées, et rendre de nouveau cette sorte de technologie aux institutions publiques.

Dans votre conclusion, vous dites clairement qu'il faut arrêter l'établissement de corporations à but lucratif. Je pense que vous voulez voir clairement dans le projet de loi les détails à propos de comment le gouvernement va le faire, c'est-à-dire annuler les hôpitaux privés et, deuxièmement, annuler les cliniques privées pour MRI.

M^{me} Turcotte: Oui, puis on a besoin du côté public de ces appareils qui existent dans ces cliniques. On veut surtout prévenir l'érosion du bon personnel, des bons technologues, ceux qui s'en vont au côté privé et ensuite on manque de personnel dans le système public. On a besoin de retenir ces gens-là. On veut avoir tout ça plus concret dans la Loi 8.

M^{me} Martel: L'autre problème autour du « poaching », pour utiliser le mot anglais, c'est que les

frais ou l'argent qu'on aurait pu utiliser pour les patients est de l'argent qui est donné au profit des corporations. Alors, vous manquez deux fois, à cause du fait que vous perdez les professionnels du système public parce qu'ils peuvent peut-être obtenir plus de frais et, deuxièmement, l'argent qui aurait été utilisé pour les patients et au service des patients est utilisé, au lieu de ça, pour les profits. Alors, c'est bien clair qu'on doit mettre fin à tout ça si on appuie vraiment le medicare.

Deuxièmement, vous dites que les membres du conseil devraient être élus ou peut-être proposés par les groupes représentant des partis ou des patients. Alors, vous voulez avoir une sorte de mécanisme où les groupes, par exemple les groupes pour les personnes âgées, peuvent nommer quelqu'un et le gouvernement doit accepter cette personne. Est-ce vrai?

M^{me} Turcotte: Il faut absolument que ce conseil-là soit élu de façon démocratique, sinon il va devenir un organe du gouvernement. Il ne faut pas qu'il y ait personne qui a aucun intérêt, soit financier ou politique, dans ce conseil-là. Il faut vraiment qu'il soit la voix du peuple, puis qu'il ait des pouvoirs plus grands pour pouvoir investiguer si le système de santé fait ce qu'il est censé faire.

M^{me} Martel: Alors, changer le mandat du conseil parce qu'en ce moment c'est trop restrictif. Ceci dit seulement que le conseil peut surveiller ou faire des chiffres, faire des statistiques à propos de la situation de la santé, mais ne peut pas offrir vraiment des recommandations concrètes pour améliorer la situation de la santé. Alors, améliorer ou élargir ou ajouter quelques responsabilités au conseil.

M^{me} Turcotte: C'est ça.

M^{me} Martel: Est-ce que vous voulez voir aussi une situation où le conseil peut faire des recommandations à propos de comment le gouvernement doit faire face aux résultats des rapports? C'est-à-dire, s'il y a un rapport qui dit qu'il faut dépenser plus d'argent pour la santé publique, est-ce qu'il y a une obligation, une responsabilité de la part du ministère, de dire oui ou non ou pourquoi, au lieu de seulement continuer à faire un travail qui obtient des chiffres mais qui ne permet pas du tout une possibilité de faire des recommandations?

M^{me} Turcotte: Oui, on leur dit clairement dans le texte que nous voulons que ce conseil ait le pouvoir de faire des recommandations au ministre.

M^{me} Martel: Le gouvernement doit répondre ou, sinon, doit dire pourquoi pas au public.

M^{me} Turcotte: De façon transparente pour le public.

M^{me} Martel: Finalement, vous dites au début, « Nous trouvons que la Loi 8 telle qu'elle est présentée actuellement n'assure pas l'implémentation des principes contenus dans la Loi canadienne de la santé et n'améliore pas le processus démocratique, la transparence et la coresponsabilité dans le système de santé. » C'est assez sévère comme observation, je dois vous dire, parce que c'est bien clair que le gouvernement dit publiquement, « Voilà un projet de loi qui va améliorer la situation de medicare, qui va garder tout ce qu'on veut avoir dans le

système de santé. » Mais vous dites clairement qu'il y a une grande différence entre les détails dans le projet de loi et la « rhetoric ».

M^{me} Turcotte: L'intention est bonne, la rhétorique est bonne, mais nous voulons des initiatives concrètes, peut-être des détails plus substantiels dans le corps de la loi.

M^{me} Martel: Alors, des détails concrets à propos de comment le gouvernement doit vraiment protéger le système de medicare ici en Ontario.

M^{me} Turcotte: C'est ça.

M^{me} Martel: Merci.

The Chair: Thank you, Ms Martel. We'll go to the Liberals now for seven minutes.

M^{me} Smith: Merci, madame Turcotte. On apprécie bien votre présentation aujourd'hui. J'ai quelques questions pour vous.

Je voulais vous dire premièrement que je suis en train de faire une revue de ces établissements de soins à longue terme à travers la province. Pendant mon travail, j'ai bien su la valeur de la présence des travailleurs sociaux dans ces établissements. Ils ont une grande valeur. C'est bien apprécié. Ceux qui ont une travailleuse sociale ou un travailleur social sur leur staff sont très bien servis. Alors, je voulais juste vous faire remarquer ça en passant.

J'apprécie bien aussi vos craintes sur les soins à domicile que vous avez notées. C'est tout à fait une crainte de ce gouvernement qu'on ait eu des coupures dans le système de soins à domicile, et on essaie au fur et à mesure d'adresser ces concernes.

J'avais deux questions spécifiques que je voulais vous adresser sur votre présentation. Je devrais vous dire que j'ai essayé de suivre votre présentation en français et en anglais, et votre traduction n'est pas tout à fait égale. Alors, je vais avec la présentation en français.

M^{me} Turcotte: Le texte français fait juste résumer certains points.

M^{me} Smith: Je vais vous poser mes questions en anglais, mais vous pouvez me répondre en français parce que je comprends bien. C'est juste parce que je ne m'exprime pas toujours aussi bien en français sur les termes.

With respect to block fees, I had a question. You suggested that it's difficult to know what's legal and what's not. To have a list of services provided by a physician, you have to pay \$100. I just wondered what you were referring to then. We've had some discussions around block fees—there's a provision in the legislation now—and we're looking for directions specifically from the presenters on how they think that block fees can be better managed or dealt with. So I just wondered what your experience was, because I didn't quite understand what you were getting at.

M^{me} Turcotte: Je ne peux pas parler pour les autres, mais moi, personnellement, je ne suis pas claire exactement sur ce qui est permis par l'Ordre aux médecins, à quel point ils peuvent facturer des frais additionnels. Puis je ne pouvais pas avoir la liste non plus de l'Ordre des médecins à moins de payer 100 piastres.

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M^{me} Smith: Votre médecin ne vous donnerait pas la liste sans payer?

M^{me} Turcotte: Comme je n'y vais pas souvent, il n'est pas accessible.

Je sais que tous nos clients ne vont pas contester ce que le médecin demande, puis les frais qu'il demande. Ils vont probablement juste les payer sans se demander s'ils sont légitimes, s'ils sont justifiables, parce qu'ils ont bien trop peur de se retrouver sans médecin. Alors, vous pourriez avoir un abus du côté des médecins à ce moment-là.

Ms Smith: That's a concern we have heard about lack of information surrounding block fees, as well as accessibility, feeling that there's kind of a "key money" system, that you have to pay the block fee in order to retain a physician. We've heard those concerns.

I just wanted to ask you as well about the formation of the council. You've proposed that you think they should be elected and that they should be representative of users of the system and experts from various areas in the province, and I totally agree. Coming from northern Ontario, I'm always a proponent for northern representation.

You've also gone on to say that they shouldn't have a financial interest. If we took that strictly, that would include not having nurses, who are probably paid within the system, or not having doctors, who are probably paid within the system. That's not what you mean, right?

M^{me} Turcotte: Non.

Ms Smith: You would allow for those kinds of participation. You're talking more private provider interests?

M^{me} Turcotte: Oui.

Ms Smith: OK. I just wanted to clarify. I think one of my colleagues had a question for you as well.

Ms Wynne: I apologize. I'm going to speak in English. I can't produce it as well as I can understand it.

Two questions. The first one is following up on Monique's question about the democratically elected council. Can you explain what you mean by that? Are you talking about another level of government? I'm just not sure how that would work.

M^{me} Turcotte: Ce qui est proposé, c'est que les membres seraient nommés par le gouvernement. Alors, c'est à ce point-là qu'on s'oppose. On veut que les membres de ce conseil-là soient proposés par des groupes, par les usagers des services, par les régions, par des groupes d'intérêt, pour être vraiment plus démocratiques, pour être la voix du peuple et non un organe d'un gouvernement.

Ms Wynne: The issue being the representation from around the province of various groups.

M^{me} Turcotte: Oui.

Ms Wynne: My second question is a more general question. I take your points. I understand that there's clarification needed.

You made the point that you thought the principles and the preamble were good, so do you think it's a good idea for us to be attempting to put into legislation a bill that would reaffirm our commitment to medicare? Do

you think this is a good direction to be going in? Given that there are amendments that need to come, given that there are changes that need to be made to the legislation, which we've acknowledged, do you generally think this is a good idea, or is this something that is not worth doing, that shouldn't be attempted?

M^{me} Turcotte: Il y a tellement d'amendements qui devraient être faits au projet de loi que je suis d'accord avec le monsieur qui a proposé la recommandation à Monique de demander au gouvernement d'arrêter le processus, de s'asseoir, puis de la rédiger selon ce qu'on suggère dans le processus courant, la consultation, plutôt que d'essayer de passer la lecture de ce bill-là avec plein d'amendements qui sont contestés.

Les principes du préambule sont bons, mais c'est loin d'être acceptable dans le reste du texte.

The Chair: Thank you.

ST JOSEPH'S HEALTH CENTRE SUDBURY

The Chair: Now we've got St Joseph's Health Centre Sudbury. Come on forward. Welcome, Ms Ashcroft. You've got 30 minutes to make your presentation. You can use that time as you choose. Any time that is left over after the presentation will be shared among the three parties equally. This time around we'll be starting with Ms Martel and the New Democrats asking the first question.

If I can get the members' attention, the floor is yours.

Ms Margaret Ashcroft: Good afternoon, ladies and gentlemen of the standing committee on justice and social policy on Bill 8, the Commitment to the Future of Medicare Act, 2003. St Joseph's Health Centre Sudbury is honoured to have this opportunity to provide you with our comments and concerns around Bill 8.

To begin, as the current past-chair of St Joseph's Health Centre Sudbury I would like to take a few moments to provide you with a brief history of our organization. As I am certain you are aware, the St Joseph's Health Centre was created as a result of the Health Services Restructuring Commission in 1997, when they announced the creation of l'Hôpital régional de Sudbury Regional Hospital that has as its goal to move from three current acute sites to one acute site.

At that time, St Joseph's Health Centre was created in order to ensure that the tradition of the Sisters of St Joseph of Sault Ste Marie of providing high standards of health care was continued through the creation of a lay community, a lay community board that now oversees the day-to-day operations of the St Joseph's Health Centre, which is the previous Sudbury General Hospital here in Sudbury. This is done in partnership with the l'Hôpital régional de Sudbury Regional Hospital through a legal contract.

As part of the contract, St Joseph's Health Centre also ensures that our ethics, mission and spiritual and religious care components as a Catholic organization are lived out on a daily basis. In addition, as part of the contract, the long-term agreement is that St Joseph's Health Centre

will manage and oversee the complex continuing care beds currently situated at the Laurentian site. The government recently announced in August 2003 that these beds will be transferred to the new St Joseph's Villa Sudbury site situated at Laurentian University, one kilometre down the road, in order to provide a more appropriate setting for these chronic patients. We look forward to fulfilling our long-term role. Actually, at St Joseph's Villa we had our official opening last Friday, so we were very proud of that.

St Joseph's Health Centre Sudbury supports the overall theme and intention of the Ontario government's Bill 8, the proposed Commitment to the Future of Medicare Act, 2003, the preservation of a universal public health care system in Ontario for the future. Like your government, we too are committed to the five principles of the Canada Health Act: public administration, comprehensiveness, universality, portability, and accessibility. The fundamental values of accountability and improvements to the system are important elements of the philosophy of Catholic health care.

St Joseph's Health Centre aims to provide the highest quality care with respect and compassion to all in need regardless of religion, socio-economic status or culture. We collaborate in open partnerships with other members of the Sudbury community's health care system and are dedicated to voluntary community governance to ensure accountability to the government and to those we serve.

Our organization has more than 50 years of health care history, providing exemplary care for all Sudburians. We have an outstanding record of good stewardship and have taken leadership roles in many areas of need. For your information, it was the sisters who actually built the first hospital in Sudbury more than 100 years ago, and then the second hospital almost 50 years later. We have set high standards in providing palliative and pastoral care, as well as in clinical and organizational ethics that are emulated by other providers. Most recently we identified the need for and we accepted responsibility for building a new long-term-care facility in order to meet the needs of seniors in our community. We are pleased to indicate that this project was completed under budget.

As a Catholic facility we reflect a proven, community-based, voluntary approach to governance. Our board of directors is representative of the cultural, linguistic, socio-economic and religious composition of our community. Throughout Sudbury's history we have clearly stated the intent of the board in Catholic health care to remain an active participant in all sectors of Sudbury's health care system into the future and to work collaboratively for positive change and progress.

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As active participants, we recognize and applaud the government's desire to preserve medicare for the future well-being of all Ontario residents and to a system where public accountability and the shared responsibility of consumers, health service providers and governments are important and fundamental components. Our board also supports the concept of a health quality council.

Catholic health institutions, including St Joseph's Health Centre, are leaders in accountability. We are mindful of the responsibility to ensure that taxpayers' dollars are spent wisely while ensuring that the community has access to the quality health care services required. In fact, in our previous history as the Sudbury General Hospital we always had a balanced budget and did not have a need to request additional operating dollars to fund deficits. Currently, we are participating with the l'Hôpital régional de Sudbury Regional Hospital in their recovery plan efforts to reduce its operating deficit by also reducing our overall operating budget. We feel that, dollar by dollar, this goal can be accomplished. We strongly feel that Catholic health care organizations should be accountable to the taxpayers of Ontario, and we feel it necessary to do our part to ensure this happens.

Having stated our support for Bill 8, we would now like to take the opportunity to address where we believe the bill might be improved in order for it to meet its intent. We are thankful that the minister and staff are open to hearing from their partners in health care such as ourselves in order to try to ensure that Bill 8 is able to meet its goal of a stronger Commitment to the Future of Medicare Act. I will speak according to the way in which the bill is laid out.

Part I, Ontario Health Quality Council: The formation of a new overarching health council provides an excellent opportunity for an unbiased body of experts to review all aspects of the health care system. However, as it is described in Bill 8, hospital board members and hospital executives are currently excluded from representation on this council. Bill 8 states that the Lieutenant Governor in Council is to have regard for the desirability of appointing experts in the health system to the council. According to Bill 8, these people would be experts in areas of patient and consumer issues, health service provision, governance, accountability and public finance, and there should also be persons from the community with a demonstrated interest or experience in health service as members.

All hospitals and long-term care facilities and services within Ontario have community members who have been elected from local residents to serve on their boards of directors. We would therefore recommend that we, as members of boards of health care facilities, be considered for inclusion on this council.

Part II, health services accessibility: St. Joseph's Health Centre Sudbury commends the government on its commitment to prevent two-tier medicine, extra-billing and user fees. However, part II of Bill 8 appears to jeopardize arrangements between hospitals and some of the physicians that hospitals currently pay directly, such as pathologists, hospitalists and on-call physicians.

This is inconsistent with the Health Insurance Act of Ontario as it exists today and it could create a problem in hospitals if physicians are not paid their salaries. It is important to change these portions of the act since it is already difficult for many hospitals to obtain the services of physicians. We therefore recommend that parts of Bill

8 be clarified in terms of how it interacts with the Health Insurance Act.

Part III, accountability: St. Joseph's Health Centre Sudbury supports the underlying principles of sections 19 and 20 of part III of Bill 8, which set the foundations and definitions for accountability within Ontario's health care system. We applaud the government for its leadership in this area. We note and support especially "that accountability is fundamental to a sound health system" and that accountability should consist of: clear roles and responsibilities; shared and collective responsibilities; transparency; quality improvement; fiscal responsibility; value for money; public reporting; consistency; trust; reliance on evidence and a focus on outcomes.

However, we have difficulty with part III of Bill 8, where it outlines methods for achieving this most important goal of accountability. Rather than facilitating accountability, we believe that Bill 8, as drafted, gives the Minister of Health and Long-Term Care direct and strict controls over health care providers and powers that may substantially interfere with the governance of health care organizations. These provisions make the existence of voluntary hospital boards irrelevant and effectively eliminate Catholic health care in Ontario. For Catholic health care organizations, a major role of our board is to ensure that not only are the legal and professional standards of care upheld but also that the values and mission of our institution are lived out on a daily basis.

More specifically, our areas of concern are as follows. First, part III represents a significant and fundamental shift in direction for the health care system in Ontario from one of non-profit, charitable organizations with accountable voluntary boards that are created from elected community members to a system of government agencies. As a voluntary board, we work hard on behalf of the Sudbury community we serve and we do not welcome the possible takeover by the provincial government of our work. We feel that changes are necessary to Bill 8 that would not negatively impact on volunteerism and the fundraising efforts of our board.

In addition, the wording of the bill indicates that the health care sector would become accountable only to the Minister of Health and negates the need for community boards. This does not ensure openness nor accountability to the community we serve. While Bill 8 has very serious implications for the governance of all hospitals and many other health care facilities, if passed as currently drafted, we feel it would eliminate Catholic health care in the province of Ontario. The voluntary nature of governance and our sponsors' responsibilities for that governance is a fundamental tenet of Catholic health care and, without it, all Catholic hospitals, long-term care and mental health services would cease to exist.

We wish to remind this government of the ongoing commitment from all three provincial parties to the mission of Catholic health care and our governance structures. These commitments have been reaffirmed frequently throughout Ontario's history, including most recently from our Premier, Mr McGuinty.

Second, this bill would require organizations to sign accountability agreements. This would seem to be contrary to the principle of limited liability that excludes personal liability for signing officers of corporations. Rather, according to the Public Hospitals Act of Ontario, volunteer board members should not be held liable if they act "in good faith." Our fear is that many strong and dedicated community volunteers would resign from our hospital boards for fear of personal liability, including fines upwards of \$100,000.

In addition, by having the accountability agreement signed by the institutional CEO, the bill would have the CEO report to both the board and the minister. The bill also would have the minister able to unilaterally change the terms of the CEO's employment contract. This is in direct interference with the governance process through the board's dealings with our only employee, the CEO. In our experience, the term "agreement" does not mean that one party can unilaterally impose terms on another party. Rather, in our experience, entering into a contract mutually agreeable to both parties is not only sound business but is also in accordance with contract law that stipulates that parties must enter into a contract freely.

Third, regarding privacy, there are several provisions within Bill 8 that allow for disclosure of personal information that is contrary to existing privacy legislation as well as to Bill 31, the Health Information Protection Act, 2003. We would recommend that these be clarified, amended and harmonized with other privacy legislation.

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Accordingly, we believe that many portions and provisions in part III need to be considered for refinement to ensure continuing progress and improvement in the health care system and healthy and co-operative collaboration among all parties. We also believe that a series of incentives for boards and hospitals to meet mutually agreed-upon goals and objectives will serve to encourage improvements to the system in all areas, including accountability, accessibility and quality patient care, compared to imposing punitive fines.

On behalf of St Joseph's Health Centre Sudbury, I would ask the members of the standing committee on justice and social policy to give serious consideration to our recommendations and comments.

We support the government's priority and commitment to ensuring that medicare is protected for now and for the future. We are concerned, however, that the rights and responsibilities of local communities, as demonstrated in the role and nature of voluntary boards, may be removed or vastly changed if sections of Bill 8 become law. As we noted early in our submission, removing voluntary boards from responsibility for hospitals and other health care organizations would effectively eliminate Catholic health care and its proven history of commitment to Sudbury and Ontario residents.

We want to make it clear that we are prepared to continue to work with the government and our local community partners to ensure that we remain true to our dedication to accountability, accessibility, integration and

system improvement, and the preservation of a universal public health care system in Ontario. We urge that Bill 8 be amended to allow us to continue to provide high quality health care to Sudbury's residents.

In closing, congratulations on your efforts for drafting a bill that is committed to the future of medicare for our community and province. We thank you again for this opportunity to provide input. I welcome any questions you may have at this time.

The Chair: Wonderful job. Thank you. You used up about 18 minutes, which means we've got 12 minutes left to ask you questions, which gives four minutes to each party, starting with Ms Martel.

Ms Martel: Let me start on the conclusions. You've referenced this throughout the text. The end of paragraph two: "Removing voluntary boards from responsibility for hospitals and other health care organizations would effectively eliminate Catholic health care." If I go to the bill, and I just want to be sure that I clearly understand this, this is because in your view the accountability agreements that would be set up would effectively have your volunteers just leave. They would not want to be party to liability that might come if they can't meet the terms and conditions in the contract stipulated by the minister. Is that part of the concern?

Ms Ashcroft: Yes, that's part. The other part too, Ms Martel, is that when the boards are appointed to Catholic health care hospitals/institutions, we do have a policy of having the proposed community members look at our values and our mission and everything else. If that is not in agreement with their values and missions, then obviously it is negative on ours; therefore we do have a choice of who we have on our boards. Obviously if it's a Catholic health care system, it doesn't necessarily have to be Catholics who are on the board, and in our case we do have people who are not Catholics on the board. That's not the issue. The issue is that it's people who we can appoint who have our vision and values and mission.

The other area with them would be that if there was a liability issue, then those of us—we're all volunteer members. We're all community members on that board. We have the insurance that covers us, but we're not personally liable. Therefore, if you think that for any decision that's been made you're going to be personally liable, then who would really want to sit on a board under those circumstances?

So there are two parts to that, Shelley, and I hope I answered them.

Ms Martel: I suppose a third one could be that—and this may appear to be extreme, and I'm not trying to up the ante here—you could have a minister putting a provision in an accountability agreement that would either violate or not be in keeping with the principles under which you operate. So that would be a third area where in fact some of the conditions outlined in the agreement would be ones that you just couldn't live with.

Ms Ashcroft: That's a possibility.

Ms Martel: OK. So in terms of the changes, there are a number of changes that we understand the minister is

going to propose. We're not sure what they are yet. That's coming, and we hope that comes sooner than later so we can deal with that. Do you have some suggested changes through that section that would make you more comfortable, or do you really think that the whole section perhaps needs to be done again from scratch so that we address some of these concerns?

Ms Ashcroft: I think, and as we showed in our presentation, that we can take what is proposed and we can sort of enlarge it or remove some of the things that are in there. For example, it's very important in communities that community members be on the board and not just appointed. People could just apply. You see an advert, "Please send in an application to sit on this board." Well, there are people in our community who will go on boards because they truly, truly believe in what they're doing. There is a possibility that if it's left wide open, people would just go on the board to say, "Oh, I'm on such a board. I'm on such a board. I'm on such a board." In our case, we truly believe in Catholic health care in Ontario, and as a result, that is our underlying reason for being on the board of, for example, St Joseph's Health Centre.

The Chair: Thank you, Ms Ashcroft.

Ms Smith: Thank you, Mrs Ashcroft. I really appreciate your presentation today. It was a great presentation. I'd just like to address some of your concerns.

Yesterday when we started these hearings, the minister appeared before the committee and gave his views on how he hoped that this would move forward. He also stated that he in fact was apologetic about the tone of the bill and that it may not reflect exactly what we're striving for. So we appreciate your input. I'd like to give you a copy of his statement before you leave so that you can see what proposals he's talking about that we will be bringing forward.

One of them has to do with—and I'm just going to go really quickly through your presentation. You spoke of the representation on the Ontario health council and recommending the inclusion of boards of health care facilities. In fact, in subsection 2(7) of the act, we talk about "A person who is a member of the board or a senior staff member of a health system organization...." That will be further defined in amendments. The "health system organization" is actually stakeholder groups or the colleges. So what we're looking at is precluding representatives of the stakeholder groups from being on the council, because we don't want it to just be a council of vested interests, so to speak. We would prefer to have a much broader representation on the board and, as I've been saying all along, certainly representation from regions in the province so that our northern communities are represented as well as a number of various types of stakeholders generally—users of the system, people who have worked in the system, board members. I think we are looking at all of that.

With respect to your part II, where you talk about the arrangements between hospitals and some physicians, we've heard those messages as well, from the OHA and the OMA. We're looking at section 9, and we're looking at language to address that.

With respect to page 6 of your presentation, you say, "Bill 8, as drafted, gives the Minister of Health and Long-Term Care direct and strict controls over health care providers and powers that may substantially interfere with the governance of health care organizations." And then you go into some detail.

In his statement yesterday, the minister did specify that the accountability agreements will be between hospitals, long-term-care facilities, CCACs and independent health institutions and that the agreements will actually be between the boards and the ministry. That again is where I think the tone rang through. There was in no way an intention of this government to usurp the authority of boards in administering the hospitals. I think that too will hopefully address your concern on governance issues. The boards will be asked to enter into negotiations and discussions on accountability agreements, but we won't be pushing the boards aside or anything like that. We're not dealing with governance issues at all, so your governance structure will remain in place. You'll be expected to enter into negotiations on these agreements. As a corollary, there'll be a performance agreement between the CEO and your board that would hopefully reflect the accountability agreement that is entered into between the board and the ministry.

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I think I've dealt with most of that. We do hope to elaborate on the process for reaching these accountability agreements. You did raise some concerns about the process. We hope to have some elaboration of that in the amendments.

Again, you touch on a series of incentives for boards and hospitals to meet their goals. Certainly that's part of the process that we hope to be looking at; not just accountability but also incentives, so we can use the limited resources we have to their best possible outcomes.

I thank you very much. I hope that addresses some of your concerns. I'm sure I've run out of my four minutes.

The Chair: You did, by eight seconds. Mr Wilson and Mr Klees, four minutes and eight seconds.

Mr Klees: Thank you, Ms Ashcroft, for your presentation. I want to congratulate you on how effectively you have couched your presentation. You have made the point of where you disagree with the government, but you were so very careful to compliment them on their attempt. I'm sure that was appreciated by members of the government here.

Ms Ashcroft: Thank you, but universal health care is something we all want, right?

Mr Klees: Absolutely.

Ms Ashcroft: There are lots of parts of the bill—*Interjection.*

The Chair: You have the floor, Ms Ashcroft. Go ahead.

Ms Ashcroft: Why would we come here and say all the negatives things? My cup is usually half full.

Mr Klees: The spirit certainly was appreciated, I'm sure.

I would like to speak to something specific. At the top of page 7, you refer to your concern about the effect this bill would have on voluntary boards and volunteerism, the implication for liability, and that effectively there would be a very negative signal to people who work and take very seriously, as you say, their dedication to this.

I'd like to take this one step further, because not much has been mentioned around the table here about the impact on foundations and the good work that foundations do in the province. With the signal here in this bill that effectively the minister is now going to take over the board and the very strong signal that the volunteerism here really is not being appreciated, that there are serious liability issues, what impact do you think this bill might have on the work of foundations around the province, and specifically in your case?

Ms Ashcroft: I can just refer to Sudbury. We have just set up a new foundation for the Sisters of St Joseph and also for the villa. The foundation is composed of, I'll use the word "prominent," members of the community in Sudbury—prominent in that they are involved in so many different aspects of our community, and as a result they can bring to that foundation their expertise. Basically, the foundation's job is to raise money. These people know who they can approach.

I'm actually delighted that Monique Smith mentioned that this is going to be relooked at and revisited, so some of those concerns I hope will be eliminated. But if you take it to the nth degree, they would be appointing people to foundations who probably do not know the area and do not know whom to connect with, whom to network with. We've been quite successful in that because of the people we've put on our boards.

Mr Wilson: Could I just make one quick comment?

The Chair: Very briefly.

Ms Smith: If he does, I want to, too.

Mr Wilson: Both of my great-aunts were Sisters of St Joseph: St Frances Regis—Sister Frances Regis; she might be a saint by now, although if God looks at me, I think she'd have a hard time getting there—and Sister Mary Ellis. I just want to say that since you did point out that the Liberals are in favour of Catholic governance, so are we, and we'll stick by you on that. You're right; all three parties have been through this. It seems to cycle itself about every seven years or so. Good luck to you.

Ms Ashcroft: Thank you.

Ms Smith: I just want to clarify—and I had it in my notes—that section 30 addresses some of the issues around liability of board members. If you want to take a look at that, we're happy to hear more submissions on that if you don't feel it goes far enough. As well, after the session, I think we can talk to you a little bit about Bill 8 and Bill 31, the interchange on privacy. I'm sorry I didn't give my colleague time to respond.

The Chair: Thank you, Ms Ashcroft, for coming today.

DAVE WILEY

The Chair: Our next delegation is Dave Wiley. Good morning—good afternoon, Mr Wiley.

Mr Dave Wiley: It's afternoon already.

The Chair: We haven't seen outside in a few hours, so we don't know what's going on out there.

Mr Wiley, are you here on behalf of yourself, as an individual citizen?

Mr Wiley: Yes, I am. I'm here on behalf of myself.

The Chair: Wonderful. I think you're the first citizen we've had today. Everybody else has belonged to something.

Mr Wiley: We're all citizens, in one way or another, aren't we?

The Chair: That's right.

You've got 30 minutes. You can use that time any way you like. At the end of your presentation, we'll share the remaining time among the three parties to ask you questions. It's 3:39, and the floor is yours.

Mr Wiley: It's a real pleasure as a citizen and, I will say, a retired member of the health care community, to be able to present before you today on Bill 8. It was very difficult trying to decide where to go and what to say. I had so many thoughts. I'm going back and revisiting my 30-plus years of experience as a clinician in the mental health system. I've tried to keep things short and fairly pointed. It won't be couched necessarily in nice, warm fuzzies, but some of my comments will be very clear.

This experience gave me the opportunity to start looking a little bit at the Romanow report, which I never had time to do. Now that I'm retired, I do have time to do some of these things. I looked at the three principles in the preamble of Bill 8: universality, comprehensiveness and accessibility. We've all had our own particular understanding of what we thought those terms meant. I discovered that those terms are not quite as specific as I would like to have thought. We look at universality, and one of the things Romanow referred to is that it isn't necessarily achieved through public funding. I always really expected that universality of access to the health care system in Ontario and throughout Canada would be through publicly funded services, and I think the public generally believes that too.

In terms of comprehensiveness, some of the words in there that really bothered me tremendously were "medical necessity." I think there was acknowledgement that how to determine medical necessity was a difficult task. Each of the provinces and territories make their own determinations on what they see as medically necessary. Those decisions usually are made between governments and medical associations, without a lot of input from target populations, that is, citizens.

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It also reminded me that back in, I think, the early 1990s, Dr Dorothy Pringle, from faculty of the school of nursing, started what I think may have been the first delisting committee. I searched feverishly for my address to that committee many years ago. I thought it would be

someplace in my archives of information, but I could not find it. I do recall sort of questioning and challenging: "What is the journey you're about to embark on? Where is it you're going with this? How far do you want to go, and what are the rules along the way?" The one example I do remember commenting on was the notion or idea of delisting port wine stain after a certain age. I don't know what happened with that, but I really felt that some of the northern folks with young children with that particular condition may not have real accessibility to those specialists in the health care system within a timely manner. I thought, "If we delist, maybe it's fine. It sounds good. Maybe it's good down in the Toronto area. But what about northern Ontario and other people who have certain issues with accessibility?" I don't know if anyone has come to terms with what provides a clear definition of "reasonable access." The real issue here seems to be timely access, and that's a very difficult situation. Things have slowly eroded over time.

I can give you a local example, a personal example, which I don't mind giving at all. Last September, I asked my family physician about an arthritic knee. Being a competitive soccer coach, it's somewhat problematic for me to be out in the field with young kids, training them with an arthritic knee. I said, "I think I need to see an orthopaedic fellow," and he said, "Sure, no problem. We'll refer." He referred in September. A few months went by, and I didn't hear anything. I made a phone call and they said, "We won't call you for at least a year to 14 months." I said, "I didn't know that. That's awful." I made a few calls, looked around and found an orthopaedic surgeon within three weeks in another city, made the trip to the other city and got the consultation. He gave me a recommendation of physiotherapy—that was one recommendation among a few others. I said, "It sounds good to me," and went back to my family physician, who gave me a referral for physiotherapy. He contacted the local hospital-based physiotherapy service. They assessed the condition as being a chronic arthritic condition. They said, "Maybe six months, maybe a year; it's hard to say. We're still dealing with the wait-list from 2003."

How did this all come about? It came about by a reduction of staff. They don't have the physios any more in the public hospital-based system that they had a few years ago. If you have insurance benefits, you get physiotherapy within a matter of days. So, timely accessibility certainly has to be on the agenda. I know this bill talks about those three principles, but in some way it needs to be a little clearer as to what the direction is and where things are going.

I had a question at the very beginning, in terms of trying to put together this presentation, and that is, what path or direction are we taking in health care policy? That doesn't speak directly to Bill 8—Bill 8 is a part of the puzzle; I understand that. If we ever arrive at where we're going with this, what's it going to look like? I don't have a vision of where health care is going to be down the road, and I think that's important. I think where

we're going and what it will look like is also important to all Ontarians. What appears to be the case is that health policy direction in Ontario is following a US model of managed care, with government dictating or controlling what services are to be provided, who will provide them and where it will happen. To date, citizens have had little input or say on these matters, and I think it's important that they do.

That raises the question of why we're chasing a system that's fraught with problems of cost, inaccessibility, accountability and no real solutions, because that's what's happening south of the border. As soon as you draw a line in the sand and say, "This is what we do and this is what we don't do," then you open the door to the private sector of managed care.

Ontario health benefits plans, if one is fortunate enough to have one, have increased 20% to 28% annually over the past years, a tremendous cost increase. How does that work with benefit providers? It's very simple. In the previous year, if a company pays out a million dollars, they take their 8% to 12% or 13%, add that on, divide by the number of plan members and that's the new premium for the following year. Costs are recovered very quickly. For me it's important to understand that shifting costs from publicly funded systems to the private system does not—I repeat, does not—reduce the cost for the citizens of Ontario; in fact, it adds through duplication of services. Citizens pay for those services that one cannot access in a timely fashion, and then they have an option of being able to additionally pay more money for services they can pay for or pay for through a benefit plan if they contribute to that.

I'll give you an example of a non-profit managed care provider. I had this absolutely phenomenal experience. It was something where you kind of think you know what it's about, but you don't until you're right there. It was with Kaiser Permanente, one of the largest, if not the largest, providers of managed care in the US. It was a very revealing experience that was conducted in a workshop a number of years ago. We got to role-play, and I jumped right in there. I wanted to role-play this so bad, because I wanted that experience. I got to be the clinician—I was a clinician, and I thought I was a good one.

It was a situation with a single mom with three kids. She was working but struggling. She lacked energy, and it was hurting her work performance. There was a history of specific trauma. She was anxious, fatigued, had difficulty getting the kids organized, off to school etc, was receiving pressure from the educational system, was receiving pressure from the employer etc to produce, produce, produce. In role-playing this, I thought I came up with a great proposed treatment plan that included a nice assessment protocol, very simple: a request for six sessions to be paid. I thought we could do some good work in a short period of time. Cost-effective, efficient, effective etc—sounds good. Well it was flatly turned down. I was kind of left speechless in front of this huge audience as I'm trying to show my stuff. What happened

over the phone is that this individual, who didn't have any contact with the client, just through me, the clinician, said what we will approve is five sessions where she goes on a parenting course. Well, the arbitrariness of those decisions, when you get into controlling what services are being provided and what aren't, has its problems.

I think my point is clear: We need to be clear about who's making decisions regarding the delivery of services. I personally don't support any plan that allows an increase in private sector opportunities into the publicly funded provincial plans. I just think we can't afford it, simple and clear.

Let me move on to the Ontario Health Quality Council. My understanding is that the proposal in the legislation as it is written now is that there be nine to 12 members with (1) experts within the health care system, (2) experts in governance, accountability and public finance, and (3) persons from the community with a demonstrated interest etc. The word "expert" kind of scares me. As a clinician, I've always prided myself on never, ever being the expert. Experts in people's problems are usually the ones who come to you looking for some assistance.

Around this table you could probably find more examples than I could ever begin to find about experts, expert advice and expert direction. But two come to mind: One is the corporate directors and board members from Ontario Hydro who are experts in business and, more specifically, the utility sector, who plunged the citizens of Ontario into extreme debt. Those experts dropped the ball big time.

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Another example from a few years ago is with the introduction of the EQAO testing in the school systems. I remember being on the phone I don't know how many hours, saying to people, "Three hours of testing for eight-year-old kids, 10 straight days in a row is wrong. Common sense says it's wrong." I don't think I could do it. I don't think any adult could do it. I think it was wrong. The testing protocol was wrong; the experts should have known better. So "expert" never leaves me with a good feeling.

Experts have their place, but so do the citizens of Ontario, because they're the experts in what they need and what they want and how it ought to be delivered. Obviously, the EQAO testing protocol was a recipe for reduced performance by those eight-year-old kids. Later, when the protocol was improved, there were claims that the new curriculum was working with the rise in the test scores. The better scores were probably reflective of the changed protocol and, most likely, the teachers' familiarity with the new curriculum.

So what do we have now in terms of quality out there, in terms of need for a quality council? We have our district health councils and their advisory functions. They do an admirable job. There's the Canadian Institute for Health Information—I've looked at some of the work that they have put out; they do an excellent job. The Canadian Council on Hospital Accreditation, I think it's

every three years, looks at the quality and accredits hospitals as to whether they are doing a good job. In the last number of years they have included a very clear protocol around quality assurance issues and how to organize the hospital community into one that's constantly and vigilantly reviewing how it does business.

Then there's the Institute for Clinical Evaluative Sciences who, along with the University of Western Ontario, the Centre for Addictions and Mental Health, the University of Toronto grad studies in rehab science, the faculty of nursing, the University of North Carolina, and Wilfrid Laurier, who all collaborated to produce The Hospital Report. I'm not sure what it would have cost for all those people to collaborate and bring some of this stuff forward, but in looking at the paper the other day, when I see that the ice machine breaks down and the kidney dialysis unit can't even provide ice and juice any more and we've got this kind of stuff going on, I'm saying, "Where's the money going? To the wrong place. To the wrong people." Get it back to the direct services, the people in the province of Ontario.

Then we can go to the OHA. They talk about believers in timely access, one of the fundamental principles in the preamble and in the Canada Health Act. That's not happening. They see themselves as leaders in accountability and quality care in our hospitals. It doesn't seem to be happening. Recently in the Sudbury Star, February 11, the president and CEO of the OHA announced warnings of bed closures as hospitals are facing a \$420-million deficit.

So how did these services really occur within our system? It's been a very simple matter. Year after year there's underfunding to that system. There are increased costs, whether it be for drugs et cetera. It puts tremendous pressure on the system. In order to balance the books services are cut. Front line health care professionals are laid off. That's why there's not as many physios in our hospital here in Sudbury today as there were a few years ago. That's how services in remote communities in northern Ontario will be reduced in terms of the services available.

Quality, for me, has always been the responsibility of that individual service provider right up front. I took that very seriously in my 30-plus years. It doesn't matter if it's a physician, physio, speech and language pathologist, but the regulated professionals pay hundreds of dollars annually to practise in Ontario and fall under the scrutiny of their regulatory colleges. I had an experience recently—in fact I've had a few since my retirement, running into people who I saw, families in therapy, many years ago. The operative words here are "many years ago," because they say, "Do you remember me?" I say, "Yes, I do." He says, "I have to tell you, my son is a graduate of York University," or Trent University or the University of Western Ontario. "He's done this and that. Everything has worked out so well; I'm so grateful to you and the services you provided." The services I provided at that point in my life were very clear. They were very patient-focused, very patient-directed. I met with their needs at

that time. It wasn't somebody telling me what their needs were. It wasn't somebody telling me how to provide service to those people. I took the responsibility seriously and I'm very concerned that, with more control of the issues, more accountability factors built in, that less vigilance by individual clinicians will take place in the future.

I probably could go on for another 30 minutes; I'm not sure how my time is right now. Let me say in summary that I want to return to my original question and ask this government, including all parties, to come to a clear consensus as to the direction of health care policy in Ontario and outline the specific incremental steps that are necessary to get the citizens of Ontario to where we need to be. That seems to be the real task here. I guess I'm also saying I'm not so sure that a health care quality council with experts and a few citizens is necessarily where we go. I think we have the infrastructure, but I think we need to start moving away from some of these structures and organizations in and around health care and get more of the dollars back into those direct services to be able to provide to the people of Ontario. Thank you very much.

The Chair: Thank you, Mr Wiley. You used up about 20 minutes. That leaves us with about 12, so we'll go with four each. Mr Delaney, from the Liberals, first.

Mr Delaney: Thank you very much, Mr Wiley, for your very interesting presentation. It brought to mind something one of my professors once said in class while I was learning physics as an undergrad. He too talked about the definition of expert and, very much like you, was a little sceptical about experts. He said, "You know what an expert is? X is an unknown quantity and spurt is just a little drip under pressure."

I think it's in that vein that the minister has struck the council. It allows him to gain access to a broader spectrum of input than he would otherwise gain from his staff and the people to whom he normally reports. Of course, the idea of having the membership change and revolve allows that representation to be refreshed. I think the idea here is that the council reports annually through the Legislature, which allows those of us who are in the Legislature to see the reports, to debate it within the Legislature and, of course, the report becomes a public document. The council reports, I think, are intended to encourage continuous improvement in the quality of Ontario's health system.

Among the areas that it might report on would be access to publicly available services, which would include the waiting times that you mentioned, the availability of health care professionals—something which we acknowledged through the election we have got to spend a lot of time working on. There just aren't enough professionals in the system to deliver the care. This is a long-term problem. We'd love to be able to turn it on and off like a tap, but I don't have to explain to you, with your background, what a long-term problem it is. If there are any other of my colleagues with a comment, over to you.

The Chair: Kathleen, you've got about a minute.

Ms Wynne: OK, just a quick question. Thank you for your presentation Mr Wiley. I wanted to ask you to explore for a second—you made a statement that more accountability factors built in will mean less vigilance on the part of individuals. Now, you understand that the accountability agreements would be between the minister and a board of a hospital, not an individual. Can you just talk to me about how you see that working, that more accountability leads to less vigilance? Because obviously the intent would be the opposite, right?

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Mr Wiley: I'm not sure I fully understand exactly what the minister means in terms of the accountability agreements and what those things would look like.

Ms Wynne: So they need to be laid out.

Mr Wiley: It does need to be laid out. But I guess my only concern is that when you start holding people accountable and saying, "This is what you do: (a), (b), (c), (d)," they're not open to doing (e), (f) and (g). If that's the kind of accountability that gets passed on down to the front-line regulated professional, that becomes problematic.

On the other hand—I'm going to be fairly blunt—if accountability agreements are tied to performance, those are obviously problematic for me because I'm not so sure that as an individual front-line clinician I would want to take full accountability for my performance constantly when I am working in an environment that has no controls over socio-economic policies and their effects on health care and a lot of other government policies. But I get to hold the bag at the end of the day.

If those accountability agreements are such that when the dollars don't seem to be there, instead of cutting services perhaps there are other options so services aren't cut or the front-line people aren't laid off—perhaps some of the salaries and remuneration of other people within the health care system, that is, managers, CEOs and other directors, are going to need to be pared back and they carry some of the burden and the responsibility within that system to be able to provide services to the people, but not cutting back on services. I'm not sure if that really is helpful at all.

Ms Wynne: That's helpful. Thanks.

The Chair: We'll go to the PCs.

Mr Wilson: Mr Wiley, your comments are much appreciated, with 30-plus years' service. It reminds me of a story a paramedic told me when I was going with him as my mother was going to Newmarket hospital last Tuesday. Anyone can check the records if they want. She just had to go to the fracture clinic, so it's not terribly bad.

Casino Rama in Orillia is just next to my riding. This paramedic came down from Collingwood. He said, "Our number one call at Rama is not with the patrons at the casino; it's the dealers, because of the stress." Their accountability environment is they have a camera above them on their 12-hour shifts and they have nervous breakdowns—what I would call nervous breakdowns. You, in the mental health area, would understand that.

We've heard some things about that. We've heard CUPE people today say, "If our people are so worried about their contracts or they're so worried about Big Brother, they can't do their jobs."

We all agree with accountability and it sounds great in an election. Over your 30 years, you've seen all three stripes of government try to bring in new visions, new bells and whistles for accountability. This is the first time the minister has decided that he's going to go into a volunteer board and at least give himself the power to do anything that board can do under law, including hiring and firing the executive director.

If you had your druthers, what would you rather we concentrate on? I think you said front-line services versus accountability and paperwork. I think people might want to take the paramedic's story into account, in that if you're really going to micromanage the system, you're going to drive the front-line workers batty.

Mr Wiley: Absolutely. I couldn't agree more. I would think there's tons of stress within that system, and being held more accountable all the time—it's not just being held accountable. There's nothing wrong with being held accountable. The one thing that got me through 30 years of that pressure cabin you work within, with very difficult decisions—and life-and-death decisions too, in the mental health area—is that I was accountable to the people who sat in the room with me. That was my number one prime accountability.

I had to turn my back on others. There was probably more than one occasion when I told senior types within the organization, "Just don't mess up. Just don't make things more difficult for me. Help make things easier or simpler." But my accountability has always been to clients. That's got to be number one. I think you'll find in Ontario most of the regulated professionals by far are very skilled practitioners who are accountable and believe the same as I do, that their number one and prime accountability is to the clients. That should never be put in a controversial position with accountability to an organization and the organization's vitality. It needs to be clearly going to the clients themselves. I'm not sure if that answers the question.

Mr Wilson: We're not quite sure what "accountability" means here, so your answer is as welcome as the government's.

The Chair: Thank you.

Ms Martel: Thank you, Mr Chair. Congratulations on your retirement, Dave.

Let me just focus on the council. I had a discussion with the minister about this yesterday, and I've heard some government members say this is key in terms of how the government is going to be accountable for improvements to the health care system. You rightly pointed out that there are a number of organizations that are already producing reports about the state of health care in the province now and have been doing so for a long time: DHCs, ICES. The public health unit here produces a report called PHRED that looks at indicators of obesity and heart problems etc. Cancer Care Ontario—

I've used this example a couple of times—produces reports on waiting lists in the province. Hospitals produce reports and report cards.

But that doesn't mean that anything is done to address the concerns that they raise. For Cancer Care Ontario, for example, the auditor's report in 1990 made it really clear that Cancer Care Ontario was not meeting waiting times for getting timely cancer treatment; that the standard is four weeks, and most people were waiting 12 weeks at the time. I don't know what it is now, but I'm assuming most people still aren't getting cancer treatment in four weeks.

The concern I have is that while the government's rhetoric has been that this council is somehow going to improve health care, there is nothing here that forces the minister to respond to whatever they produce. There is not even anything here that says there is going to be one single second of debate about this report when it's actually introduced in the Legislature. The Environmental Commissioner now produces an annual report, and the Legislature doesn't debate it for one second. So I've got some real difficulty looking at this health council and saying to myself, "This is something that's going to produce some accountability," especially on the part of the government to respond to waiting lists, to respond to whatever comes forward in terms of what the council actually looks at.

Tell me again, as you read this, do you think there is anything here with respect to the work that these fine people are going to do? I don't want to knock the people who are going to come forward, but what is it that they're going to do that's going to make the government accountable for improving the state of health care?

Mr Wiley: Well, those are very good questions. My first thought, as you were asking the question, was that I think a representative from the Liberals, Conservatives and NDP should all sit in a room with a facilitator. I think you guys should really come together very clearly for the citizens of the province of Ontario and come up with how we are going to deal with this kind of an issue. That's non-partisan, and I think that serves the people, and serves them correctly.

If there is an opportunity for a health care quality council to do something that's worthwhile, I'd be the first one to back it, not a problem. I'll submit my name as one of those citizens, non-experts, to contribute to it, and I would be proud to do that.

But there are so many organizations right now. There are literally hundreds of thousands of dollars—actually, I'm going to say millions of dollars—of clinicians' time being spent right now in just that hospital accreditation process with the Canadian Council on Hospital Accreditation. It's huge the amount of time that goes in that, just to be able to get a certificate at the end of the day every three years that says you're an accredited hospital in terms of quality.

There are structures in place. If this is something new, and it can be devised that it can be additive, that there's added value to this, I don't see it as a problem. I don't

even see it as a big expense necessarily, but there are some tremendously expensive structures in place in organizations right now. I think they need to be cut and slashed, not the front-line services to the people of Ontario. I guess that's what I'm trying to say.

The Chair: Thank you, Mr Wiley. We do appreciate your coming.

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RURAL AND NORTHERN NETWORK, NETWORK 11

The Chair: Our final presentation of the day is from the hospital network—that's either 11 or 2.

Mr Joe Pilon: It's 11.

The Chair: The spokesperson for that group is Joe Pilon. Mr Pilon, welcome. You have somebody else with you, obviously; if that person would introduce themselves for Hansard when you start. You have 30 minutes. You can use that time any way you like. Any time that is left over after the presentation will be divided amongst the three parties in equal amounts. It will be the Progressive Conservatives' turn to start the questioning. The floor is yours. It's 4:14.

Mr Pilon: Thank you very much. Good afternoon, ladies and gentlemen, and thank you for this opportunity to address you today. My name is Joe Pilon. I'm the CEO of the Espanola General Hospital and the Blind River District Health Centre, two hospitals in small communities west of here. This is Tom Querney, who is the chair of the board of the Sudbury Regional Hospital. He will be helping with this address as well.

I am here today as the spokesperson for network 11 of the Rural and Northern Network. I'd like to just tell you what that network is about. It includes six hospitals and two CCACs: the Sudbury Regional Hospital, the West Parry Sound Health Centre, the Espanola General Hospital, St Joseph's General Hospital in Elliot Lake, the Blind River District Health Centre and the Manitoulin Health Centre, which has two sites, one in Little Current and one in Mindemoya. The two CCACs that are members of our network are the Manitoulin-Sudbury Community Care Access Centre and the Algoma Community Care Access Centre. Many of the hospital CEOs and board chairs are with us in the audience today.

That network was formed in 1999. It was part of the rural and northern health care framework, which was recommended by the health services restructuring committee and endorsed by the Ministry of Health and Long-Term Care. Our mission is to explore operational efficiencies and coordinate patient flow before, during and after hospitalization.

Today I really just want to focus on two areas in part III, the accountability part of Bill 8. I'd like to talk about the alternatives to accountability agreements, and then Tom will talk about the impact on the independence of voluntary hospital boards.

The members of network 11 support the government's attempt to provide accountability in the health service

sector. We are mindful of our responsibility to ensure the taxpayers' dollars are spent wisely while ensuring that our communities have access to the quality health care they need. However, we believe that the accountability agreements and compliance directives, as proposed in the current bill, are not appropriate ways to achieve these goals.

Firstly, the members of network 11 are concerned that the proposed legislation does not define the parameters within which the Minister of Health can force a hospital to sign an accountability agreement. According to section 21, entering into the agreement is done by direction and not by mutual purpose or negotiation. As well, there is no appeal process for a hospital that feels it does not deserve to be party to such an agreement.

In his speech to the standing committee yesterday, the Minister of Health outlined the goals of Bill 8. Minister Smitherman stated that the bill will protect essential health care services and preserve the sacred principle that Ontarians should have access to medically necessary health care services based on need. Our commitment in our communities and our responsibility as board members and CEOs has always been to protect essential health care services for our communities and to ensure access to care based on need. We believe that negotiation of the accountability agreement is essential to capture the diversity of our communities and the uniqueness of their individual health care needs.

For most hospitals in Ontario, there are many factors beyond their control that impact the provision and delivery of health care. For example, expenses are outpacing revenues due to the following key cost drivers, and I'm sure you're aware of them: growth of an aging population, cost of new drugs, cost of new technology and diagnostic equipment, recruitment and retention cost pressures.

The wage increases and inflationary pressures currently represent 60% of all of our expenses. In 2002-03 alone, those expenses increased by 14% due to salary increases in union wage settlements. In many cases, these were settled by the courts. Hospitals have no choice but to pay them.

It is not clear with the current wording of the bill what weight will be given to these factors or what obligation the government has to fund these costs. As board members and CEOs, we are guardians of the public trust, and we take that obligation very seriously. The minister and the government have that same obligation, the obligation to act in the public interest. That obligation is set out in section 9.1 of the Public Hospitals Act. We're concerned that that's not in Bill 8, and we think this requirement must not be set aside by that bill. Therefore, the members of network 11 believe that Bill 8 should be amended to enhance the accountability of the government to the citizens of Ontario and more clearly define those situations that will warrant its intervention.

Protecting essential health care services and ensuring access requires adequate resources. The obligation of the government to resource the system as appropriate to the needs of the system is not set out in Bill 8; it should be. It

should be set out to ensure shared responsibility and accountability.

Secondly, it will take a complex infrastructure and bureaucracy to implement these agreements, one that the Ministry of Health and Long-Term Care currently does not have. This added cost to the currently financially pressured system will take resources away from direct patient care, away from the patient and into added bureaucracy.

Thirdly, the bill makes reference to individuals in executive functions. Presumably, this means the hospital CEOs.

Today's modern hospital boards operate under the principle that board members establish corporate policy and set the strategic direction for the institution. They have one employee and one employee only. That's the CEO. To him or her, the hospital board members delegate the good management of the hospital's day-to-day operations. All other positions within the hospital corporation fall under the CEO's leadership and direction. In this way, the hospital CEO has only one master, the board.

The accountability agreements proposed in Bill 8 would change this relationship by introducing the possibility of placing the CEO under ministerial control. While we hope that the government will strive to maintain a collaborative approach when dealing with hospital governance issues, it is very possible that the CEO could find him or herself receiving conflicting direction from two masters: one from the community board and another from the Minister of Health in the form of a compliance direction. This would completely undermine the important principle of local input and involvement.

In addition, it appears as though the intent of the bill is to make hospital administrators personally responsible for their institution's performance. In sections 26 and 27, the minister has been given the power to modify and even nullify a pre-existing employment contract negotiated between the hospital board and the CEO. We think this provision will render recruitment of senior managers even more difficult in northern communities.

It has been shown that small and remote hospitals have a difficult time achieving provincial benchmarks due to their inability to consistently maintain the critical mass that creates efficiencies and the isolated nature of their practice. The challenges in a northern community can be daunting to a CEO, and to assign personal responsibility to the CEO and punitive action would make recruitment and retention even harder.

The members of network 11 strongly believe that hospital boards must be free to include in the CEO's employment contract whatever recruitment incentive will work. Furthermore, they must be able to rely upon these negotiated terms. In addition, the members of network 11 believe that any reference that assigns personal accountability to a person in an executive function should be removed from the bill.

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Fourth, the Public Hospitals Act sets out powers for the Ministry of Health to intervene. Section 9 gives the

minister a clear and absolute right to assume and exercise all of the powers of the board and members of the corporation. We believe that this gives the government adequate power and authority to address any governance or management issues of public and government concern.

Finally, it appears as though most of the system reforms proposed in Bill 8 are already being analyzed by the multi-year funding and performance agreement task force of the joint policy and planning committee. This is a partnership between the Ministry of Health and Ontario hospitals through the Ontario Hospital Association. This partnership has been forged to recommend and facilitate the implementation of hospital reform within the broader context of the health care reform agenda in Ontario. One of the deliverables of that group is to discuss and evaluate the face validity of performance agreement templates and the mediation strategies therein, which would be presented by the Ministry of Health. What is different from Bill 8 is that the terms in the multi-year performance agreements would be based on measurable indicators. There would be incentives in place to encourage and reward good performance, along with mechanisms of resolution for bad performance.

Another fundamental difference is that the working group will be making recommendations on relief for hospitals when the Ministry of Health fails to deliver on its obligations.

Myself and other CEOs in the audience are actively participating in these working groups. We believe in and are committed to this process. We recognize the need for system transformation and we want to achieve it. However, the success of this transformation will only be through a mutual belief in and a commitment to the process.

This brings us to our second section, and Tom.

Mr Tom Querney: I will begin by stating that the members of network 11 agree with the government's statement found in the preamble to Bill 8 that a strong health system depends on collaboration between consumers, health service providers and governments, and a common vision of shared responsibility. That is why we are disappointed to discover that the current wording in Bill 8 does not adequately address this direction.

In the first place, section 22 gives unilateral power to the Minister of Health to issue a compliance directive for health providers to change their operations. There is no explicit provision for consultation. The members of network 11 are concerned that this section could be used to undermine the accountabilities undertaken by voluntary hospital boards with their communities.

In his December 17, 2003, address to hospital board chairs and CEOs at an OHA meeting, Health Minister Smitherman valued the significant contribution volunteers make to hospital governance. He further suggested that hospitals need to remain connected with their local communities. We agree with Minister Smitherman's advice. Network 11 hospitals are already responsive to community needs, and we are accountable for our performance.

Community board members have a governance responsibility to plan and direct the delivery of programs based on local need and within the funding envelope provided by the Ministry of Health. But it should be recognized that our northeastern Ontario communities are unique with their needs and challenges. For example, board members in network 11 know that local residents have historically reported higher rates of smoking and obesity, and this translates into higher morbidity and mortality rates than the rest of the province. We also know that our geography, climate and physician shortages restrict access to primary care services, more so than in the rest of the province. We keep these factors in mind when setting the strategic direction for our hospitals. We are accountable to our communities because we live and work there.

The members of network 11 are concerned that a ministerial compliance directive under section 22 may not fully take these factors into consideration. We believe that section 22 should be amended to be better aligned with the principles of shared and collective responsibility, transparency and trust that are identified in section 20 of the bill.

The government should recognize the contribution that voluntary hospital boards make to the health care system. The men and women who sit on network 11 hospital boards are dedicated individuals who devote many hours of personal time and many of whom drive long distances to attend board meetings, to participate in committee work and to further their trustee education, all without remuneration.

The members of network 11 believe that it is only through the involvement of local stakeholders that hospitals can be truly responsive to their community. If the ministry wants to proceed with accountability agreements and directives, then the unilateral powers found in part III should be tempered by adding a mandatory consultation phase. They should be negotiated to achieve buy-in, and the agreements should be balanced by articulating exactly how the ministry will fulfill its accountability for funding the programs and services needed to ensure quality outcomes and achieve better accessibility.

Network 11 board members are also committed to the efficient operation of their hospitals. We all participate in the acute care hospital report card, the largest patient satisfaction survey in North America. We do this because our boards believe in being accountable to the communities they serve and to constantly improve by comparing performance against that of peers. The geographic realities of northeastern Ontario, however, do not always make these goals achievable.

Hospitals in network 11 face a unique set of challenges. These include service delivery issues that arise as a result of travel distances, isolation, inclement weather and transportation difficulties. In addition, our hospitals provide much more than acute care therapeutic services. In some communities, we dispense primary care, long-term care and respite care, and coordinate post-acute community-based services. We are also the source for

diagnostic services, rehabilitation and mental health. We must staff and resource essential services such as critical care, emergency and obstetrics, even when patient volumes are not high enough to achieve economies of scale.

In addition, the lack of post-acute services in some areas delays a patient's discharge from hospital and increases the hospital's proportion of alternate level-of-care days. This adds to system cost and reduces hospital-length-of-stay efficiency measures.

For these reasons, the members of network 11 believe that when hospitals do not meet their performance expectations, they should work collaboratively with the Ministry of Health to determine the cause. We should not be punished, as is contemplated in Bill 8, but encouraged and supported by the ministry to find a solution.

In closing, I simply want to stress the importance and added value of the voluntary nature of hospital boards. The ability to advocate and seek resources to provide quality health care based on local needs is important to network 11 hospitals, and this role supports the government's commitment to the Canada Health Act and ensuring accessibility.

We urge the government to proceed in a more collaborative fashion when trying to achieve greater accountability. Accountability agreements, if they are judged to be a necessary tool, should be negotiated between the parties and not imposed unilaterally. Hospitals are prepared to work with the ministry to set clear performance measures and targets, but they must be bilateral. They should foster the interdependent nature of the relationship between health care providers and government, one that should be characterized by trust, mutual respect and collaboration.

Bill 8 provides a tremendous opportunity to facilitate meaningful transformation of the health system in Ontario. We support the general principles enunciated by the government and believe that success in system change will be through a mutual belief in and commitment to the process. That concludes our remarks.

Mr Pilon: I was remiss, if I could, in describing network 11. I forgot to acknowledge all of the support we get from the district health council here, the Algoma, Cochrane, Manitoulin and Sudbury District Health Council.

The Chair: Each party has five minutes to ask you a question, starting with the PCs.

Mr Wilson: Thank you, gentlemen, for your presentation, and I guess, wearing my old hat, thank you for eventually coming together in network 11, since I was the minister who sponsored the authorship of the rural and northern health care framework. I take credit for the good parts and I blame the bureaucrats in the Ministry of Health for the bad parts. What else is new in politics?

Joe, I just want to ask, the only example the minister gave in his remarks to the committee yesterday as to why he needs a performance agreement—and it's one that's sexy for the public—is, "Hey, PCs, you really tried to get the ratio of full-time versus part-time nurses up." He said

that's why he needs it, so he can compel hospital boards to correct that, for example. I would think it's more a function of the budget that he gives those hospitals, rather than whether they want to have full-time or part-time nurses, or it may be—and the reason I triggered it was the volumes you mentioned. You have such a diverse region and probably unpredictable volumes throughout the members of the network. Can you see a reason in your area, in all honesty, why the minister would want a compliance agreement there or an accountability agreement or whatever? Is there a problem that really needs to be fixed that you guys have been hiding from the ministry or that you're not playing ball with the ministry on that he as a new minister would within his first four months—within his first three months, actually, was when he first thought of this idea—say, "I have to go after those hospitals. I have to take over their boards"?

1630

Mr Pilon: I can't come up with a situation in my hospitals that needs that attention.

Mr Wilson: As northern minister for four years, I can tell you that I never read anything on your network that was that bad.

Can you just comment on the nursing thing, though? I know that's maybe more a Toronto-based one because of the volumes of nurses they're dealing with. But that was the only example he has given us to date of why he needs these extraordinary powers. Of course, that sounds good to the public, but, as I said, I think it has more to do with financing.

Mr Pilon: The nursing one can be a challenge in northern and rural hospitals in trying to maintain a baseline of service for volumes that are somewhat inconsistent. To maintain cost controls and flexibility sometimes you need more part-time staff than full-time staff. On the other hand, that creates a recruitment challenge. To try to draw people into the field when there are no full-time jobs is not a great strategy. You have to balance that with your requirement to have a balanced budget and operate within that budget.

Mr Klees: I'd like to just follow up on the issue of the control that the Ministry of Health wants to have and effectively take the control away from the local board. In York region, which I'm most familiar with, we have three hospitals, and there have been numerous times when, due to local stresses and local situations, we've had to effectively do battle with the Ministry of Health to get them to understand the local issue. Being so close to the centre, to Queen's Park, we have a hard enough time trying to get Ministry of Health staff to understand why there should be some latitude in one particular budget envelope and why we need certain accommodations.

I can't imagine what it would be like, for example, for northern Ontario to get the Ministry of Health officials, as well-meaning as they might be, to understand the nuances of the pressures that you have. I'd be interested in your comment on what the impact would be on you as a local hospital being able to manage those local issues if in fact the Minister of Health effectively is saying to you,

"We'll look after it. You comply with our direction." What would the implication be to your organization?

Mr Pilon: It would obviously depend on what that agreement looked like. In my organizations, if I think about Espanola and Blind River, we have created some integrated models that allow a lot of flexibility in addressing the community needs, that allow us to move resources into Meals on Wheels, supportive housing and those kinds of things, because we have long-term care, we have supportive housing and we have other programs that help serve the community.

That flexibility and that ability to meet the community need would be important to maintain. Having said that, that may be recognized in an accountability agreement. I don't know. We would certainly hope that that would be recognized and we would seek to see that if it becomes a negotiated process, which is what we believe needs to happen.

Ms Martel: Thank you to both of you and to your colleagues, some of whom have come a long way today to be part of this process.

I want to focus on where the minister might be coming from with respect to part III in particular. You said in your remarks that the minister addressed hospital board chairs and CEOs on December 17. I don't want to put either of you on the spot, but were either of you there?

Mr Querney: Yes, I was.

Mr Pilon: Yes.

Ms Martel: Did he talk about the bill at all, because the bill would have been introduced by then? Did he make reference to it?

Mr Querney: I don't recall that, but I certainly recall that he was indicating that there would be changes afoot in the ministry and with the hospitals in particular.

Ms Martel: Did he give you any indication at the time, during that presentation, what would be driving those changes? What was driving his need to bring forward changes with respect to boards and hospital operations?

Mr Querney: The OHA has telegraphed repeatedly the growing deficits that hospitals are facing, so the cost pressures on the operating side as well as it relates to capital projects. So I believe the minister is responding to some of those pressures, those cost pressures in particular.

Ms Martel: Deficit pressures.

Mr Querney: Possibly.

Ms Martel: All right. If the minister had a concern about a deficit in a hospital—maybe he thought it was completely out of control, the incompetence of the board, fraud, whatever you want to deal with—surely under the Public Hospitals Act—and you would know this better than I; I apologize, because I don't know all of the criteria—he could intervene in one specific hospital if he thought there was a serious problem around deficits and why those deficits were growing. Am I correct?

Mr Pilon: That's correct.

Mr Querney: I was just going to say that we actually lived that at the Sudbury Regional Hospital. We under-

went an operational review and then the appointment of a supervisor.

Ms Martel: Yes, well, we won't go there, will we? That mess is not sorted out yet, despite all the promises made by the local member. We hope they will be.

What then would drive the minister to have a more blanket approach? Because that is what this bill entails. Now we're going to have a bill that essentially allows him a broad range of powers that are quite sweeping in a number of areas to ostensibly, in terms of what you heard, try and deal with a deficit problem. If you want to do that, if you think there's a problem, then you use the Public Hospitals Act and address it that way.

The method here is really broad. I think it's really draconian. I think it's going to force board members to flee en masse, especially when they look at the liability sections of this bill, if something isn't done to address this. Is that your read of where we're heading here?

Mr Querney: Certainly that's one perception. I think it all revolves around exactly what is entailed in those accountability agreements.

Ms Martel: Do you see that there is even a need for them, though? That's my other question. Is this really a broad, draconian response to a concern that may be actually more readily got at by using the Public Hospitals Act in those hospitals where you think there's a problem around finances?

Mr Pilon: My assumption is that they believe this is a better way than having to put the supervisor in. Our position is it's not a better way. It's not a way to achieve the goals. It is just new legislation that creates the same old directives, and that's not how you reach mutual belief in a process or commitment to a process.

Ms Martel: I've assumed that the powers here are even more sweeping than contained in the Public Hospitals Act.

Mr Pilon: And they take away the responsibility to act in the public interest, which is something of grave concern for us in the north, I think.

Ms Martel: Right, because that at least is in the Public Hospitals Act—it hasn't been transferred to this bill—that there had to be some action that's in the "public interest." That doesn't appear here.

Mr Pilon: No.

Ms Martel: In terms of how we respond to this, you have said part of this has to be amended. I'm not sure you can amend some of this, because some of the provisions are just so broad in terms of what the minister is allowed to do in any number of sections: 22(1), 22(2), 26, 24. At any time, anywhere, any place, the minister is going to be able to do whatever he or she wants. I don't know that you can really amend this unless you remove most of this and start again.

Would your view be that if the minister really wants to get at some issues in some hospitals, do that under the Public Hospitals Act and don't move forward with provisions which appear here, which really are very sweeping in the powers that he or she would now be allowed to have? Do you have a recommendation on

what's the better way to try to achieve what allegedly is a deficit problem here?

Mr Pilon: My view is—

The Chair: It will have to be a 12-second recommendation.

Mr Pilon: My view is the powers are there under the Public Hospitals Act if there is a need to intervene with direction. There may be, and should be—I recognize the need to increase accountability. I think that's a good a goal, and we should do that. This doesn't seem to achieve it in its current form. In an amended form, it may.

Ms Smith: Mr Pilon and Mr Querney, thank you very much for appearing before us today. I appreciate you recognizing that you're also affiliated with your district health councils I met with last week. They would be happy to know that they're being acknowledged as well.

I'm sure that through your association you have heard that there have been ongoing discussions between the minister himself, the ministry staff and your association, among other stakeholders, on possible amendments to this legislation. I'm hoping some of that will have calmed some of your fears with respect to the legislation, although I appreciate that you have come forward with a number of those again today.

1640

I'd just like to go through your presentation, and I'm going to talk really fast because I've only got four minutes. I'm happy to discuss with you afterwards any other questions you have.

You were concerned that "the proposed legislation does not define parameters within which the minister ... can force the hospital to sign an accountability agreement." That's one of the issues that I think has been addressed with the OHA, and we are looking at proposed amendments that will include language around the negotiation of the accountability agreements. I think you're also aware that the accountability agreements that the ministry is looking at will be between the ministry and the board and not the CEO and that there will be an expectation there will be a performance agreement between the CEO and the board. I think that has gone some way to calming some of the concerns out there.

You talked about Bill 8 being "amended to enhance the accountability of the government to the citizens of Ontario and more clearly define those situations that will warrant ... intervention." Again, I think you'll hear through the discussions that have been held that there will be amendments put forward around sections 21 and 22 around process before directives are issued within an accountability agreement framework.

You raised a concern about resources, and particularly the bureaucracy required to implement these agreements. As I understand it, there are presently funding agreements in place with health care providers. I think those resources that are in place to negotiate those funding agreements will also be there to negotiate accountability agreements, and it's our hope that those things will start to mesh together into some kind of framework.

I think I've already addressed your issues about the CEOs not being part of an accountability agreement. Therefore, your CEOs will not be receiving conflicting direction, which you raised.

Again, you raised concern about the ministry taking action against a CEO or against a board. I think you'll see in the proposed amendments that we'll be looking at a very specific framework within which action would be taken. It would only be in extreme circumstances where the minister would intervene in a board or in a CEO's activities.

You talked about the joint policy and planning committee. I think they're doing some fabulous work and it's certainly the expectation that that work would continue and that the accountability agreements that we're looking at would work within that framework, that they would blend together. So the work that's being done there would not be lost in any respect but would form some of the work into accountability agreements.

There was one other thing. I think I'll let Ms Wynne speak, because my head is a little muddled at this point. If I figure something else out that I want to raise, I'll bring it up to you later. Thanks.

Ms Wynne: I just had a very quick question of clarification: You talk about the particular issues in the north and the accountability agreements. As Ms Smith has said, there are going to be amendments around that, but I just wanted to get at whether in principle you object to the accountability agreements. With the appropriate structure and clarity around them, can you support that idea?

Mr Pilon: Yes. I have no objections to an accountability agreement. I understand the reason for that; it's the way it seems to be unfettered in this bill that gives us concern as a network.

Ms Wynne: Great. I just wanted to get that clear.

Ms Smith: Sorry, I remembered my last point, which Ms Wynne actually just raised. You discussed the particular needs in the north, and I just wanted to note that we have two northern members on this committee, so your concerns are well attended to in this committee. I think that those concerns will be addressed in negotiations and discussions leading up to an accountability agreement. There will be plenty of opportunity for the health care providers to make their submissions or input into the process so that the particularities of the north or of any specific region or any specific health care provider will be taken into account when developing these accountability agreements.

The Chair: Final question of the day goes to Mr Duguid.

Mr Duguid: Thank you. I noticed in your presentation you talked about the powers the ministry has under the Public Hospitals Act to take over a board. I should probably know this, but I don't: What is the difference between those powers and the powers being proposed under Bill 8? If they already have the powers to take over a board, then how does Bill 8 change those powers?

Mr Pilon: I think the point is why does Bill 8 need to create these powers if they're already there?

Mr Duguid: I guess my question—and I say this constructively—if those powers have always existed, and I know the previous government did use them on a couple of occasions, probably under extreme circumstances—

Mr Pilon: But the powers under the Public Hospitals Act also qualify that the minister has to act in the public interest. It clearly sets out how that public interest is there

and the use of cabinet, those kinds of things. That's not in Bill 8.

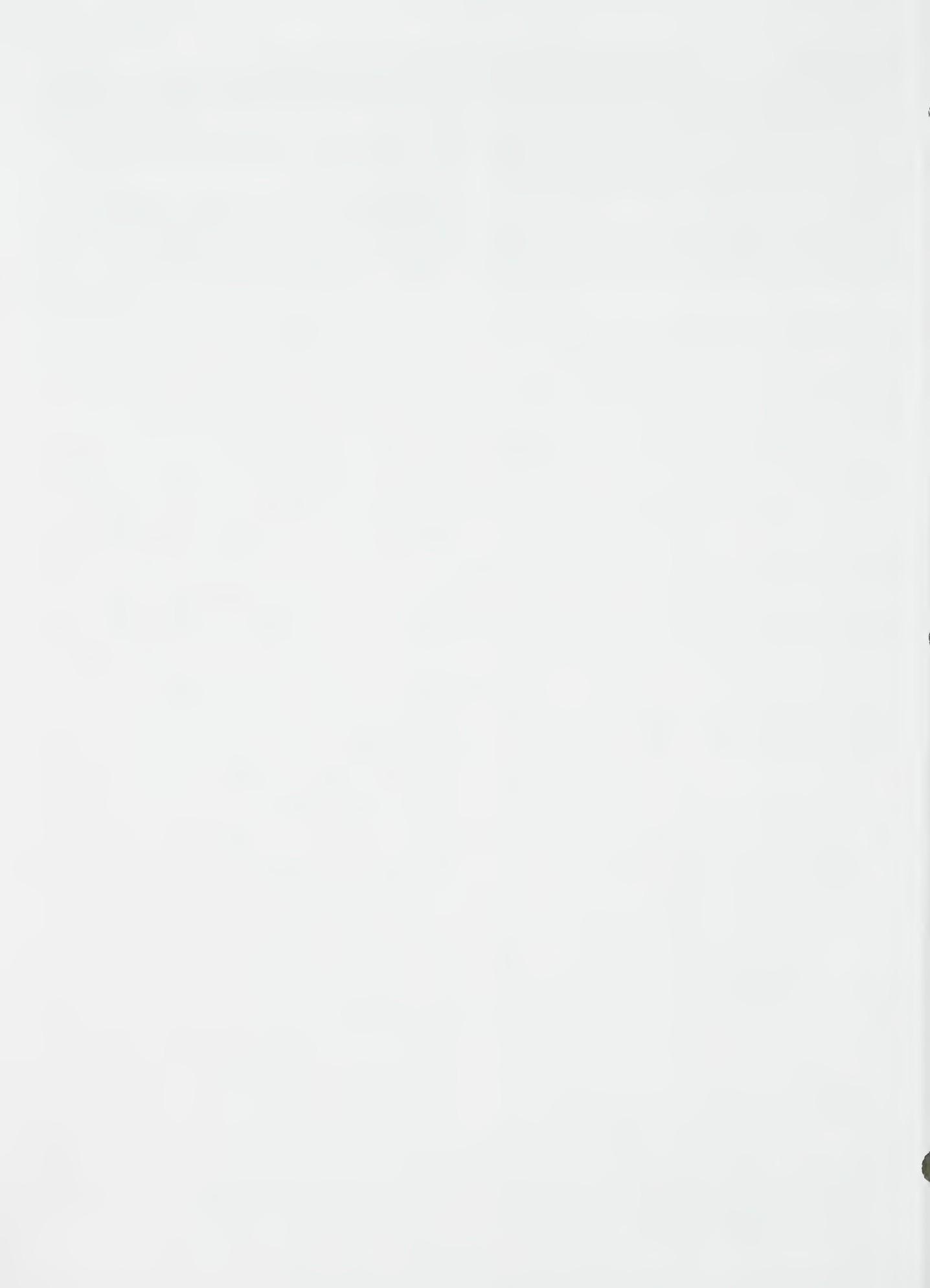
Mr Duguid: So the public interest aspect is the difference between the two pieces of legislation?

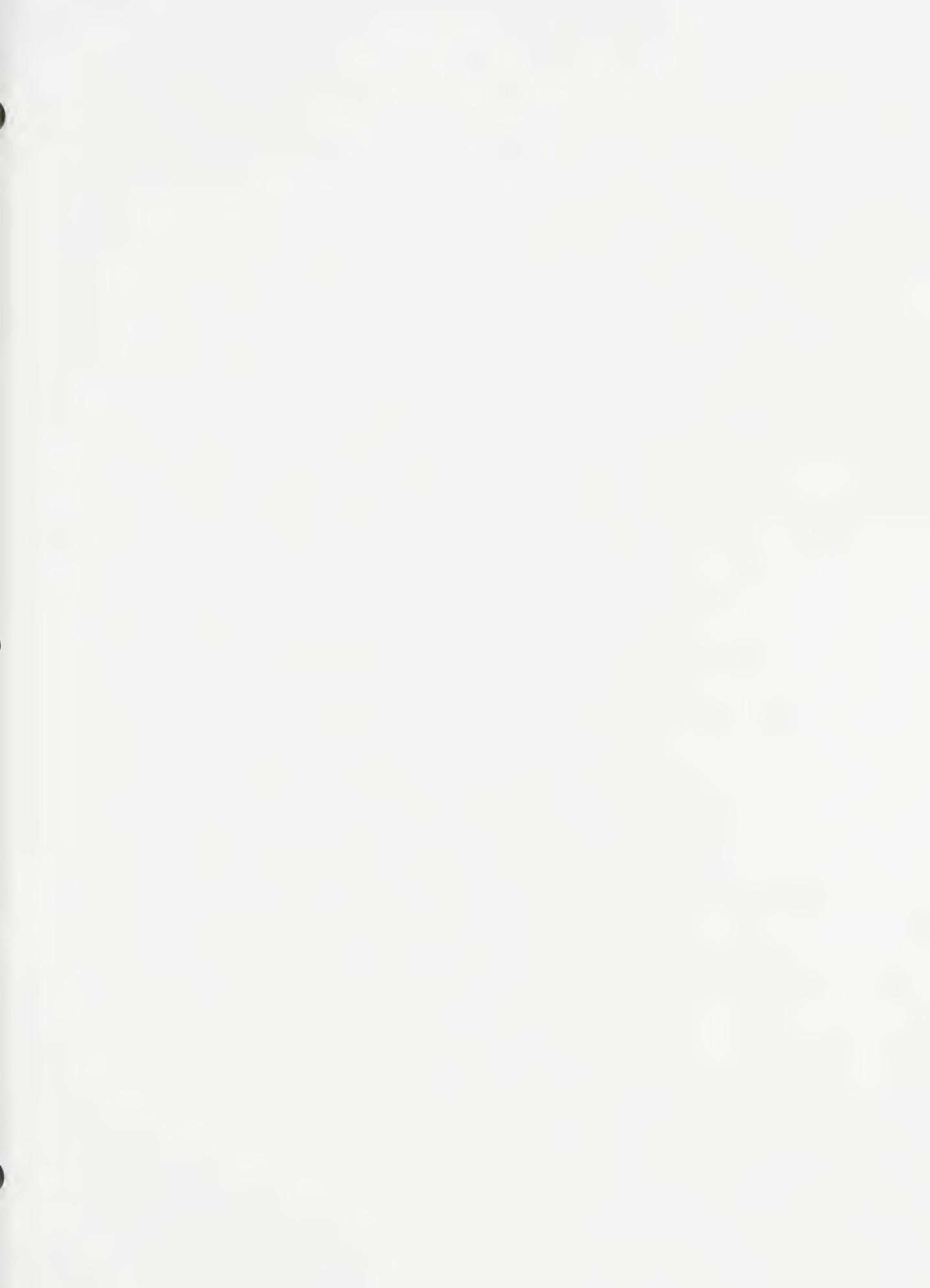
Mr Pilon: Correct.

Mr Duguid: OK, thanks.

The Chair: Thank you, Mr Querney. Thank you, Mr Pilon. We are adjourned to Ottawa. We all need to be at the front doors for the bus at 5:20; planes leave at 6.

The committee adjourned at 1647.





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First Session, 38th Parliament

Official Report of Debates (Hansard)

Wednesday 18 February 2004

Standing committee on
justice and social policy

Commitment to the Future
of Medicare Act, 2003

Assemblée législative de l'Ontario

Première session, 38^e législature

Journal des débats (Hansard)

Mercredi 18 février 2004

Comité permanent de la
justice et des affaires sociales

Loi de 2003 sur l'engagement
d'assurer l'avenir
de l'assurance-santé



Chair: Kevin Daniel Flynn
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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON
JUSTICE AND SOCIAL POLICY

Wednesday 18 February 2004

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

COMITÉ PERMANENT DE LA JUSTICE
ET DES AFFAIRES SOCIALES

Mercredi 18 février 2004

The committee met at 0903 in the Courtyard Marriott Hotel, Ottawa.

COMMITMENT TO THE FUTURE
OF MEDICARE ACT, 2003LOI DE 2003 SUR L'ENGAGEMENT
D'ASSURER L'AVENIR
DE L'ASSURANCE-SANTÉ

Consideration of Bill 8, An Act to establish the Ontario Health Quality Council, to enact new legislation concerning health service accessibility and repeal the Health Care Accessibility Act, to provide for accountability in the health service sector, and to amend the Health Insurance Act / Projet de loi 8, Loi créant le Conseil ontarien de la qualité des services de santé, édictant une nouvelle loi relative à l'accessibilité aux services de santé et abrogeant la Loi sur l'accessibilité aux services de santé, prévoyant l'imputabilité du secteur des services de santé et modifiant la Loi sur l'assurance-santé.

The Chair (Mr Kevin Daniel Flynn): Good morning, ladies and gentlemen. I call this committee to order. I would ask people to take their seats. For those members of the committee who are here, checkout time is 12:30, so judge your time and your packing accordingly.

HÔPITAL MONTFORT
MONTFORT HOSPITAL

The Chair: Our first presentation this morning is from l'Hôpital Montfort. We have four people with us: Gisèle Lalonde, president; Marcel-Guy Bélanger; Michelle de Courville Nicol; and Bernard Grandmaître. Would you come forward, please.

Welcome and thank you for coming. If I can explain the rules to you a little bit, you've got 30 minutes. You can use that time any way you choose. At the end of the presentation, we'll split the remaining time among the three parties to ask you any questions they may have as a result of the presentation. The sequence of questioning will begin in the first round with the official opposition, the Progressive Conservatives.

Having said that, the floor is yours, and I've got 9:06.

M^{me} Gisèle Lalonde: Monsieur le Président, membres du comité, permettez-moi d'abord de vous remercier de

nous donner l'occasion d'exprimer notre point de vue sur le projet de loi 8, une mesure législative qui aura un impact majeur sur le système hospitalier de la province, et un impact que nous devons qualifier de dévastateur sur l'Hôpital Montfort, une institution essentielle à la survie de la communauté franco-ontarienne, et sur la communauté franco-ontarienne dans son ensemble.

Our views can be summed up in two words: Not again. It is extremely difficult for Franco-Ontarians to fathom how a Liberal government could even propose to pass a law so draconian, so totalitarian, that it brings us back to the sad days of the ill-advised and unconstitutional proposed closure of our hospital by the Ontario Health Services Restructuring Commission.

Bill 8 is nothing less than a blatant and dangerous attack on what Ontario's linguistic minority considers to be a sacred trust: the Franco-Canadian's ability to make decisions that affect the development and the future of its own institution, the Montfort Hospital.

Cette loi menace en fait de nous soutirer le pouvoir qui nous permet d'assurer la survie de l'Hôpital Montfort, une institution essentielle à la survie de la culture et de la langue de la minorité. À l'heure actuelle, nous avons les outils pour prendre et mettre en vigueur n'importe quelle et toutes les décisions qui permettent à Montfort de continuer à jouer son rôle essentiel.

Il n'y a également aucun doute dans notre esprit que cette loi va à l'encontre du principe constitutionnel fondamental du respect et de la protection des droits des minorités linguistiques, tout comme le faisaient les actions de la Commission de restructuration qui ont été rejetées unanimement par trois juges de la Cour d'appel de l'Ontario et trois juges de la Cour divisionnaire en première instance.

Le pouvoir de prendre des décisions qui ont un impact sur la vie de notre communauté est important pour la société ontarienne dans son ensemble, mais il est absolument vital pour la minorité linguistique d'avoir ce pouvoir au sein de ses propres institutions. C'est une réalité qui a été confirmée par plusieurs jugements de cour, particulièrement dans le secteur de l'éducation, et plus récemment dans la décision Montfort.

The Supreme Court's Mahé decision, which was quoted in the Montfort judgment, is often cited as the cornerstone of all the decisions involving the importance of leaving this decision-making in the hands of the minority. It says: "... minority language groups cannot

always rely upon the majority to take account of all their linguistic and cultural concerns. Such neglect is not necessarily intentional: the majority cannot be expected to understand and appreciate all of the diverse ways in which educational practices may influence the language and culture of the minority."

What the highest tribunal in the land is telling us, in the end, is simply common sense. Cultural decisions taken in the interests of the linguistic and cultural minority have to be taken by people who understand this minority. And as hard as they may try, as empathetic as they may be, members of the majority cannot achieve that.

A francophone institution is more than a service counter where French is spoken. There is also a crucial cultural element involved in decision-making. For the Franco-Ontarian community to receive proper services, it must be able to decide how those services will be provided. Only francophones can make those decisions. In the case of a hospital, these decisions are made by the board of trustees.

Voici ce que disait de l'Hôpital Montfort la Cour d'appel de l'Ontario dans son jugement historique :

« Nous sommes d'accord que Montfort joue un rôle institutionnel plus large que la prestation des services de soins de santé. En plus de remplir la fonction pratique supplémentaire de dispenser la formation médicale, le rôle institutionnel plus large de Montfort comprend notamment celui de maintenir la langue française, de transmettre la culture francophone et de favoriser la solidarité au sein de la minorité franco-ontarienne. »

Le ministre de la Santé croit-il vraiment qu'il peut remplir cette mission mieux que les membres de notre communauté? La communauté franco-ontarienne ne permettra pas au gouvernement de l'Ontario d'empêcher l'Hôpital Montfort de jouer ce rôle essentiel à la survie de la minorité linguistique de l'Ontario.

0910

Our volunteer members from the Montfort board of trustees will address more fully questions that concern them more directly in their depositions, but let me tell you that from the community's vantage point, we see this law as nothing more than a hostile takeover by the minister of an institution that Franco-Ontarians built. We see nothing more than a deliberate attempt to do away with the bothersome intermediaries that are the volunteer board of trustees.

Vous placez une énorme épée au-dessus de nos têtes, et vous dites que vous ne vous en servirez pas. Si c'est vrai, pourquoi sortir l'épée? Pourquoi vous donner et donner à tous les ministres et à tous les gouvernements qui suivront des pouvoirs aussi excessifs? Il n'y a qu'une réponse possible : parce qu'il viendra un jour où vous déciderez de vous en servir.

Plus encore, nous sommes estomaqués de constater que cette loi est l'idée saugrenue du Parti libéral que plusieurs Franco-Ontariens ont fidèlement appuyé au fil des ans, peu importe où le vent soufflait. Notre communauté vous a soutenus lorsque vous couliez, et maintenant

que vous voguez allègrement, ce sont les remerciements que nous méritons.

C'est honteux. Et ce l'est pour tous les Ontariens qui s'attendaient à ce que ce gouvernement leur offre un leadership qui encouragerait l'inclusion et la participation des gens, plutôt qu'une plus grande exclusion que même le régime précédent.

Monsieur le Président, c'est une chose pour votre comité de nous entendre aujourd'hui. Nous l'appréciions. Mais c'est une toute autre chose d'inclure les Ontariens, dans un esprit de confiance mutuelle, dans la prise de décisions qui touchent directement leurs vies quotidiennes, telles que l'administration et la gestion des institutions de santé.

On nous demande de vous faire confiance. Franchement, de notre perspective, c'est trop demander. Les Franco-Ontariens ont vécu trop de tristes expériences où leur confiance s'est avérée mal placée.

Our volunteer members from the Montfort board of trustees will address more fully questions that concern them more directly in their depositions, but let me tell you that from the community's vantage point, we see this law as nothing more than a hostile takeover by the minister of an institution that Franco-Ontarians built.

Nous sommes aussi troublés par un autre aspect de cette Loi 8. Les mots de l'ancienne loi précisant que le ministre doit agir « dans l'intérêt public » ont été mystérieusement rayés du nouveau texte. Ce curieux amendement fait sonner toutes sortes d'alarmes à Montfort. Car, coïncidence des coïncidences, lorsque la Cour d'appel a tranché en faveur de Montfort en décembre 2001, l'une des raisons invoquées était que, contrairement à son mandat, la Commission de restructuration n'avait pas agi « dans l'intérêt public ». En effet, l'intérêt public exigeait qu'elle tienne compte du principe constitutionnel du respect et de la protection des droits des minorités linguistiques.

Pourquoi ces mots ont-il été effacés du texte de la nouvelle loi? On nous dit que ça ne veut rien dire, que le ministre doit quand même agir dans l'intérêt public. D'accord. Mais alors, pourquoi ne pas tout simplement laisser ce passage intact?

Le texte entier de cette loi dégage une odeur malfaisante, comme si l'objectif exprimé n'en est pas la véritable intention.

Monsieur le Président, j'ai eu l'honneur de mener une lutte de cinq ans pour sauver l'Hôpital Montfort. Nous y sommes parvenus pour la seule et unique raison que la communauté franco-ontarienne était massivement et activement impliquée dans la cause, comme elle le démontrait le 22 mars 1997, lorsque 10 000 défenseurs de Montfort remplissaient le Centre municipal d'Ottawa à craquer pour le plus grand ralliement de l'histoire franco-ontarienne. Si cette Loi 8 avait été en vigueur, il est difficile de m'imaginer comment cette communauté aurait senti le besoin de se rallier pour défendre un hôpital contrôlé par le ministre. La décision inconstitutionnelle de la Commission de restructuration aurait bien pu être incontestée. L'Ontario serait privé aujourd'hui de

son unique hôpital d'enseignement francophone, et la communauté franco-ontarienne aurait subi un tort irréparable.

As president of the SOS Montfort movement, I said I would remain at Montfort as long as the hospital's survival was threatened in one form or another. With this bill today, it is.

Merci. Thank you.

The Chair: Thank you, Ms Lalonde. Are you ready to receive questions now, or will there be further presenters?

Ms Lalonde: We thought maybe at the end you could ask any of us to answer your questions.

The Chair: OK. Mr Grandmaître, then?

Mr Bernard Grandmaître: Am I next?

The Chair: That's what I'm asking.

Mr Grandmaître: That's good. Excuse my gravel voice.

Monsieur le Président, membres du comité, permettez-moi d'abord de vous dire que je ne suis pas ici de gaieté de cœur aujourd'hui. En fait, ceux qui me connaissent seront passablement surpris de me voir ici. Ils sauront qu'il a fallu quelque chose de très important pour que je me déplace pour venir devant vous.

I am a Liberal—I don't need to hide it, Jim or Frank; they all know it—fast and true. I always was a Liberal and always will be. I am sitting here today as a Liberal, a former member of the Legislature like yourselves, and one who has had the honour of being a minister in the David Peterson government. But as a Liberal, I have seen better days. This law, Bill 8, is not the product of the Liberal Party that I know. In fact, it is in flagrant contradiction to some of the most basic principles that inspire and have always inspired my party.

While claiming that it will make hospitals more accountable to the people, Bill 8 is disenfranchising the people from the decision-making process by rendering insignificant the boards of trustees of hospitals. In doing so, it is dealing a devastating blow to the future of Montfort Hospital, a major and crucial Franco-Ontarian institution which the community has just waged a bitter five-year fight to preserve.

Cette loi n'est rien de moins qu'un bris de confiance et des principes démocratiques. Comme le disait M^{me} Lalonde, il est difficile pour moi de croire que c'est un gouvernement libéral qui la propose. De toute évidence, aucune considération n'a été donnée quant à l'impact qu'aurait cette loi sur la communauté franco-ontarienne. Et cela, même si, depuis le jugement de la cause Montfort, le gouvernement de l'Ontario, particulièrement le ministère de la Santé et des Soins de longue durée, devrait savoir que toutes les décisions et les politiques gouvernementales doivent être considérées en fonction du principe constitutionnel du respect et de la protection des droits des minorités. Car cette loi signifie que la communauté ne sera plus en mesure de prendre les décisions nécessaires à la survie de son institution, l'Hôpital Montfort, une institution essentielle à la survie

de la minorité franco-ontarienne. Le ministre de la Santé est incapable d'assumer pleinement cette responsabilité.

Mr Chairman, members of the committee, let me underline a rather embarrassing coincidence. As minister responsible for francophone affairs in 1986, I too fathered a Bill 8. Exceptionally, it was approved by all three parties of the Legislature. It was a momentous day, an historic day, one that is fondly remembered by all Franco-Ontarians. My Bill 8 was in fact the French Language Services Act. When Franco-Ontarians speak of "la Loi 8," cruel irony, isn't it? Less than 20 years later, here we are, here I am, fighting "la Loi 8" that poses a clear and present danger to the Franco-Ontarian community.

0920

Just to remind the members of the committee what spirit guided members of the Legislature in approving the French Language Services Act two decades ago, let me read part of its preamble:

"Whereas the French language is an historic and honoured language in Ontario and recognized in the Constitution as an official language in Canada;... and whereas the Legislative Assembly recognizes the contribution of the cultural heritage of the French-speaking population and wishes to preserve it for ... generations...."

Strong enough for you?

Mr Chairman, members of the committee, there is a lot more to recognizing the cultural heritage, and especially preserving it for generations, than providing translation at these meetings. Only strong francophone institutions can achieve the goal set out by the legislators in this act. Francophone governance is an integral part of the francophone institution. To do anything else is not only bound to fail; it is absurd.

Let me add to this that Ontario's Court of Appeal stated in the Montfort judgment that the province's French Language Services Act is a quasi-constitutional law, which gives it legally more weight than this Bill 8.

Les temps changent. Comme politicien, je le reconnaiss. Mais des principes aussi fondamentaux que les droits d'un des peuples fondateurs de ce pays ne changent pas. Le jugement de Montfort est fondé sur la constitution qui créait le Canada en 1867, également, en grande partie sur les principes et les clauses contenus dans la Loi sur les services en français de l'Ontario.

La Commission de restructuration l'a fait au nom de l'efficacité. Aujourd'hui, ce gouvernement le fait au nom de l'imputabilité. Ça recommence. Les prétextes changent, mais nous connaissons la méthode. Passez le rouleau compresseur sur tout le paysage et ne dérangez surtout pas ce ministère avec des réalités sociales ou des faits constitutionnels. Et nous voici donc à nouveau, là où aucun d'entre nous ne veut être : à défendre nos droits d'exister et de prospérer dans cette province. Nous devons en remercier, une fois de plus, le ministre de la Santé.

At this time, I'd like to céder la parole à M^{me} Michelle de Courville Nicol, présidente sortante de l'administration de l'hôpital Montfort.

M^{me} Michelle de Courville Nichol: Monsieur le Président, membres du comité, en tant que présidente sortante du conseil d'administration de l'Hôpital Montfort, je suis offusquée par cette loi. Je suis offusquée comme membre du conseil, je suis offusquée comme bénévole, je suis offusquée comme représentante de ma communauté et je suis offusquée comme Franco-Ontarienne.

Je passe droit au but.

This law is apparently being proposed in the name of "accountability." Over the years, especially the last decade, we have heard many key phrases of this kind being used by governments to explain their actions. As Mr Grandmaître pointed out, sometimes it's "efficiency." Sometimes it's "better access." Sometimes it's "rationalization." Very often it's imposed by governments, usually in what seems like a desperate rush, and rarely does it live up to its own grand promises. Does the party now in power at Queen's Park tell us that health services restructuring was a great success? I doubt it. Yet that commission, created by the government, had all the right key phrases too.

We change governments; we change the flavour of the month. Now it's accountability. And it is imposed with a law so drastic, so totalitarian, that it rivals in scope the powers that were ceded to the restructuring commission by the previous regime, except this time it's the minister who seeks to increase his own power over hospitals and over the communities they serve.

But we will deal with this question of accountability, because Montfort Hospital is not afraid of accountability. We, as members of the board of trustees of the only francophone teaching hospital in Ontario, as well as our management, have always been accountable to our community. We have to be accountable. We can't afford not to be accountable. We are the beginning and the end of the health care stakes for Franco-Ontarians. Every decision Montfort makes has a direct impact on the future of the Franco-Ontarian community and its self-sufficiency in health care. Francophones look to us for more than French-language services. They look to us for francophone doctors and health professionals in Ontario in the future. They look to us as a vital part of their network of institutions. They look to us as a beacon that tells them they belong in Ontarian society.

We have inherited a noble but onerous responsibility. We are condemned to excellence, and thus to accountability. Montfort has always been accountable. While we were for years the most underfinanced hospital in Ontario—a situation that was recently redressed—we were accountable. In fact, we were at that time and still are today one of the most efficient hospitals in the province, with one of the lowest costs per weighted case. Our track record of the last eight years speaks for itself. As our community has often done, we did a lot with very little. Franco-Ontarians do not take money for granted, whether it comes from the government or elsewhere.

Montfort ne s'est pas opposé à la signature d'un contrat d'imputabilité ou d'un rendement de compte. Il s'agit en fait de contrats de services qui vont au coeur du

mandat et de l'avenir d'un hôpital, puisqu'ils déterminent les volumes de services alloués et le financement qui y est rattaché. En fait, l'Hôpital Montfort a signé le tout premier accord de rendement de compte avec le ministère de la Santé et des Soins de longue durée en octobre 2003. Mais il s'agissait d'un accord négocié, le fruit d'un processus équitable.

Bill 8 is totally unacceptable to us in its current form because it imposes unilateral, non-negotiated accountability agreements on hospitals by the minister. Minister Smitherman's soothing words before this committee on Monday in Toronto indicated the law could be changed to include negotiated rather than unilaterally imposed accountability agreements. But the way we understand it, the minister still reserves the power to impose accountability agreements at the end of the day. It is still not an even playing field. And let's make no mistake about it: That power is immense. The minister stated Monday, "In the end, only if all recourse fails and only in exceptional circumstances can the ministry impose penalties directly on the CEO." What are those exceptional circumstances? Will the next minister, the next government, stand by the same statement, or will the law be interpreted to achieve one's goals? We suspect the latter.

The Ontario Public Hospitals Act already gives the minister the power to take over a hospital after due inquiry and justification, and the previous minister has already done so in our community, among others. But this new law gives the minister the power to take over the entire management of a hospital for no other reason than the fact that he wishes to do so. It is a measure that goes against what has been the cornerstone principle under which our hospital system has functioned throughout our history: voluntary governance.

When one takes into consideration Montfort's essential role in preserving the language and culture of the Franco-Ontarian community, the minister's proposed powers will cause irreparable harm to that community. At Montfort, we respect the principle of accountability, but I would like to ask the minister and his bureaucrats, where is your accountability when it comes to the Franco-Ontarian community? The Ministry of Health is not accountable to the Franco-Ontarian community, yet the minister wants to take the responsibility to adequately respond to the health needs of the Franco-Ontarian community away from us and take it upon himself. You will forgive us if we greatly fear the results. To strip us of governance in such a way for no reason at all and with predictably disastrous results is a major affront. We hope the wisdom that escaped others who came before you will be brought to bear to help find a solution that is agreeable, fair and just to all Ontarians.

Now I'd like to introduce Mr Marcel-Guy Bélanger, who is treasurer of the Montfort board of trustees.

The Chair: Just so you know, Mr Bélanger, we've got about five minutes left in your time.

Mr Marcel-Guy Bélanger: Thank you very much, and I'll respect that.

Mr Chairman, members of the committee, for weeks now, ever since I became aware of this bill, I have been

asking myself one question: Why is this Minister of Health attacking me?

What have I done that is so bad that all of a sudden this Minister of Health finds it necessary to threaten me, my fellow members of the board of trustees and the hospital's CEO with a \$100,000 fine? On ne m'a jamais dit qu'il était bénéfique d'être un crime.

Le ministre déclarait lundi que les amendes imposées par la loi étaient, et je cite, « trop sévères ». Eh bien, laissez-moi dire d'abord que c'est lui qui les a proposées au départ. Et permettez-moi de poser cette question : après avoir suggéré des amendes de 100,000 \$ qu'est-ce qu'il considère comme étant moins sévère? Est-ce que cela signifie qu'il y aura toujours des amendes?

0930

Mr Chairman, membres du comité, a-t-il quelqu'un qui a stoppé à réaliser la pleine implication de ce que cette loi dit à propos du conseil d'administration volontaire? Il implique rien de moins que nous ne sommes pas des personnes honnêtes, que nous ne sommes pas dignes de confiance, ou, au mieux, que nous sommes totalement irresponsables. Au même moment, il nous dit et notre CEO que nous tenons des postes de « grande honneur et responsabilité. » Pardon me si I don't feel that honoured right now. In fact, I feel downright bullied and belittled.

Pardonnez-moi si je ne me sens pas très honoré présentement. En fait, je me sens carrément bousculé et diminué.

Bien sûr, on nous dira que la Loi 8 ne vise qu'à traiter des cas « exceptionnels ». Peut-être. Mais nul doute que son effet est de peindre tout le monde avec le même pinceau : tous les membres de conseil et tous les PDG. Nous sommes maintenant tous des transgresseurs potentiels de la loi du ministre. Et c'est une loi hautement subjective, à être interprétée selon la compréhension et les intentions du ministre du moment.

As if fines aren't enough, Bill 8 gives the minister unprecedented power to shove us aside and take over the entire management of the hospital if he simply wishes to do so. So this law is basically asking me and all my fellow members of the Montfort Hospital board of trustees, "Why would you bother being a volunteer?"

And let me ask, does anybody stop and think who these volunteers are who serve on the board of trustees? They are responsible people who have achieved responsible positions in their lives, who are respected members and representatives of their community. They are dedicated to their task, yet this bill treats them like children who have no idea what they are involved in.

There is no doubt in my mind that with this kind of law, the quality of the people who will accept to sit on boards of trustees will greatly diminish. So will their dedication, so will the service to the community, and, I dare say, so will the accountability to the community. It's telling my CEO, "Stop mustering all your energy to make Montfort one of the best and most efficient hospitals in the province. It's too dangerous. Become a consultant or something."

La Loi 8 dit à notre communauté, « Votre hôpital ne vous appartient plus. Pourquoi donner votre argent à la

Fondation Montfort quand vous savez que le ministre pourrait prendre le contrôle à n'importe quel moment? »

Il n'y a qu'un seul hôpital d'enseignement franco-phone en Ontario. C'est une fière et forte institution franco-ontarienne. Elle est essentielle à la survie de la minorité linguistique de l'Ontario. Mais elle doit reposer sur une fondation solide, et ce que fait cette loi, c'est détruire cette fondation. Elle mine la participation active de la communauté dans la vie et le développement de son institution.

It is undermining our ability to retain and recruit competent francophone administrators. Personnel retention and recruitment is already a major challenge for Montfort, given essential bilingual requirements. We are presently blessed with a CEO and a management team that we consider to be above the norm, and they are accountable. But we seriously wonder how this law will affect that situation.

We wonder what will happen the day the minister decides to impose an accountability agreement, which will cause irreparable harm to the Franco-Ontarian community. We will then, no doubt, be told that all the hospitals are being targeted. We have heard that one before, but yet again, that is totally missing the point of the impact such policies have on the minority. Especially when all it can count is one hospital, this impact is much greater. With Bill 8 we are left with no defence. Worse, we will be punished if we defend ourselves and do what we think is right.

For all these reasons we present to you today we firmly and deeply believe that this is a bad law. It must be changed extensively. We, in our management, are honourable and responsible people; we do an honourable and responsible job. We neither deserve this, nor can we accept it. Thank you for listening.

The Chair: Thank you very much, ladies and gentlemen. Your presentation was very clear, very direct and a little bit over 30 minutes so unfortunately we have no time for questions, but I do thank you for coming today. Thank you for your input.

OTTAWA ACADEMY OF MEDICINE

ACADEMIE DE MÉDECINE D'OTTAWA

The Chair: Our next delegation this morning is from the Ottawa Academy of Medicine. Gail Beck, the president, is with us. Ms Beck, make yourself comfortable. As with all delegations, you have 30 minutes to use as you please. Any time that is left over at the end of the presentation will be used by the three parties to ask you any questions of clarification. We'll be starting with the PCs again, seeing as we didn't have any questions last time, going to the NDP and then to the Liberals. Having said that, it's 9:39 and the floor is all yours.

Dr Gail Beck: Thank you very much. Mr Chair and members of the committee, I bring greetings to you from the physicians of Ottawa.

The Chair: Ms Beck, could you stop? Excuse me, if there are any conversations to take place, could they take

place in the hallway, please. I'd like to give our delegations our full attention. I'll even re-start your clock.

Dr Beck: Thank you. Je m'appelle Gail Beck. Je suis la présidente de l'Académie de médecine d'Ottawa. En tant que médecin, je peux vous dire que le projet de loi 8 peut garantir l'accessibilité aux services de santé pour mes patients à long terme.

As a patient, and as a woman of my age likely to use the health care system more and more over the next 20 years, I must say that Bill 8 may not guarantee the commitment to medicare that I would like.

My family doctor has cared for all of the members of my family—three generations—for almost 20 years. He sees us annually for our physicals, in a timely manner for our illnesses, and has provided care before my children were born, after my children were born, and attended their deliveries. He visited my mother the several times she was in hospital. Like most family physicians in this community, he works a 60- to 80-hour week and is at a greater risk for health problems himself because of his stressful lifestyle and schedule. Like the vast majority of physicians in this community, and in all communities across Ontario, my family physician provides the best health care my tax dollars could buy.

0940

One of the members of your committee whom I don't see here today, Mr Patten, in another life had been well acquainted with this city's paediatric specialists at the Children's Hospital of Eastern Ontario. The specialist physicians at that hospital and in all the hospitals of this region and in our community also work an average of a 60- to 80-hour week, twice the usual work week in many cases, to provide care to the people of this community. The patients of this community are committed to the spirit of the Canada Health Act, and with the hours the work and the dedication they provide, the physicians of this community have also proven their commitment to the Canada Health Act. Where in Bill 8 is the portion that spells out the government of Ontario's commitment to sustainable funding, to guaranteed wait-times, to ensuring sufficient health care providers for the people of Ontario? Where is their commitment to the spirit of the Canada Health Act?

Le projet de loi 8 édicte un Conseil ontarien de la qualité des services de santé. Les médecins d'Ottawa supportent cet «edict». Will the government of Ontario not just commit to tabling the reports of an Ontario health council but commit to following such a council's recommendations?

As a former member of the Expert Panel on Health Human Resources in Ontario, I know that councils and panels of this type, making recommendations to governments, take particular care to provide the best, the most timely and accurate information possible. An Ontario health council's recommendation will be taken very seriously by the people of Ontario and by their doctors. Can we not have that same commitment in Bill 8 from government?

Part II of Bill 8 outlines, first of all, a number of measures, apparently to ensure accessibility. Unfor-

tunately, accessibility is not one of the terms defined in part II. Part II seems to cover a number of measures to be taken in order to recover “unauthorized” payments to physicians. I find this to be a misleading portion of the bill. I feel that part II implies that my colleagues and I spend more time billing our patients than we do treating them. Part II implies that we are stealing. Why else would there be a reference to jail terms in subsection 17(2) of part II? I'm not saying there are no dishonest doctors, but I am saying the evidence would show you that there are no more dishonest doctors than there are dishonest lawyers or dishonest accountants or dishonest politicians.

It also upsets me that this section of Bill 8, apparently devoted to accessibility, does not at all mention wait-times. If you ask my patients or the doctors of this community what concerns them the most about health care today, in 2004, most of them will say, “How long must one wait for essential diagnostic treatments or tests?” We now have in Canada several excellent wait-time studies—for example, the western wait-list study or the MRI study produced by the Institute for Clinical Evaluative Sciences. Will the government of Ontario truly commit to accessibility and look at such things as wait-times for diagnostic tests and treatments for Ontarians?

In this regard, I would like to mention one initiative of the academy of medicine that did address wait-times, specifically the wait-time for a psychiatric referral. The academy of medicine, under the direction of Dr Keith Anderson, a local psychiatrist, set up a psychiatric referral service for family physicians in Ottawa. This service provides family doctors with access to a psychiatric consultation, and usually follow-up, for a patient within one month of the date of referral. Such an initiative really does address accessibility in this community, and yet we have struggled to get from the provincial government the funding necessary to cover the costs of administering this program.

I would now like to move to part III of Bill 8, accountability—also not defined. In January 2004, I became the acting clinical director of one of the Royal Ottawa's clinical units. Like most of my colleagues in such positions, I was honoured to have the opportunity to serve my community and my patients more effectively in this way. Having said this, like most of my colleagues, I enjoyed a pay increase of approximately zero dollars. I realize that good patient care is the result of strong clinical teams and I'm very pleased that my colleagues afford me such confidence. However, if I review part III of Bill 8, I discover that the Minister of Health has even less confidence in health professionals in “executive functions” than he does in health professionals in general.

I'm just going to read from subsection 29(1): “For the purposes of carrying out the provisions of this part, the minister may require any person, entity or agency to provide the minister with any information that the minister considers necessary, including personal information other than personal health information within the mean-

ing of the Remedies for Organized Crime and Other Unlawful Activities Act, 2001."

There must be something about this clinical director's job that no one has told me for the Minister of Health to have to have such sweeping powers over volunteer health professionals in Ontario's health facilities. I do understand that the minister yesterday indicated to you that there was a need to amend this bill and I am glad to hear it. This bill makes me feel as though I'm either a thief or a gangster and, as the representative of this region's 2,500 physicians, I assure this committee that my colleagues are devoted to the health care of the people of this region, that we welcome innovation and that we expect to be accountable in our daily work.

The work of the doctors of this city, this province and this country is second to none, and we work with the best nurses, the best pharmacists, the best social workers—in fact, the best health care providers in the world. The health professionals of Canada have delivered to the people of Canada the promise of the Canada Health Act.

Surely the government of Ontario could commit to the people of Ontario around the Canada Health Act. Will the government of Ontario hold the government of Canada responsible to the recommendations of Commissioner Romanow? That's not indicated in this bill. Will they say to the people of Ontario, and hold themselves to account, that they will do their utmost as government to fund, support, research and sustain the health care of the people of Ontario? Will they be accountable for their leadership in health care reform, as the physicians of this community have shown their responsibility?

The Chair: That's wonderful. Thank you very much. That took about 10 minutes, so that leaves each party with seven minutes to ask questions, starting with Mr Wilson.

Mr Jim Wilson (Simecoe-Grey): Thank you, Dr Beck, for taking the time to present before us today. Certainly, we should thank you for taking on the added responsibilities with no pay that you have done. When you point out section 29 in particular, where it makes a reference to the remedies of organized crime and other unlawful activities, it goes on in part II, actually, to make it clear that the minister doesn't need the patient information. He or she can get that without names through the Ministry of Health.

But it has another personal attack on what one has to presume is physicians, because it says that the minister may order the compliance directive or the accountability agreement—let's just read it exactly—to be put "in a conspicuous place when ordered to do so by the minister"; in other words, to be put up on a bulletin board in the institution or hospital, "even if this results in the disclosure of personal information."

We don't know what that means, and I'm the former Minister of Health. I have no idea what that means in terms of why the minister, for the first time that I'm aware of, would need the personal information of a physician. I assume that's your financial information or

something, because we're dealing in here with probably what the minister would think is fraud or something. Without any recourse at this point to courts or anything, I assume your billing information—I'm the minister who had to step aside for 10 weeks because one of my assistants said to Globe and Mail reporter Jane Coutts that so-and-so is a top biller. He was dismissed, but it turned out after the Privacy Commissioner's investigation that personal information hadn't been disclosed and this guy was just guessing that this particular cardiologist, who everyone in the province seemed to know was a top biller—he was relaying third-party information or, at the very best, third-hand information.

But this actually lets the minister do something that I had to sit in the penalty box for, even though I had nothing to do with it. He can actually ask you, I guess, for your personal information. Can you just tell us how you feel about that?

Dr Beck: Certainly I feel that physicians have the same rights to privacy that most other people do in our community. The other thing, I guess, from my perspective, is that if you were to look at physicians, on average, much of their income is pretty much an open book. That's why the piece about the unlawful billing is very puzzling to me. On average, the vast majority of family physicians bill the same amount of money because, on average, they all practise in the same way. The vast numbers of child psychiatrists like me have very similar billings.

The College of Physicians and Surgeons of Ontario has the capacity to investigate physicians' billings. Certainly the doctors of Ontario are not happy with how the medical review committee has conducted some of its hearings. We have reason to believe that one of our members, a pediatrician in Windsor, actually took his life because of the way he was treated by a medical review committee.

We don't dispute that those among us who may be unlawfully billing, who are very few, need to be investigated. We know that the vast majority of us are not billing any more than our neighbours next to us with exactly the same practice. It's just that easy for the Ministry of Health and Long-Term Care to examine it.

0950

Mr Wilson: On another train of thought here, psychiatrists, particularly pediatric psychiatrists, are a fairly rare breed in this province. I have one in my entire riding. In fact, she is only able to run a clinic there once a week. She is running clinics throughout the province, trying to patch up parts of the province where there are literally no services, especially for children.

Among your members, whether pediatric or otherwise, are there not a number of arrangements in place between physicians and hospitals or physicians and other medical or public institutions that are incentives to try and keep those physicians retained and attracted to those institutions?

Dr Beck: The government of Ontario is setting up alternate funding plans with a number of specialist phys-

icians or physicians of larger teaching hospital institutions. It was the view that those were to help to offset some of the disadvantages of being in academic teaching centres.

Mr Wilson: Is there any apprehension among your members that, outside of an APP or AFP, as you call it, alternate funding plan—for instance, I can think of ER. Take Collingwood, in my riding. With the ER doctors, the one psychiatrist we have who does everybody, children right through, the different specialists, outside of AFPs or APPs—alternative payment plans—the board or the foundation has had to make arrangements, with the consent of the public, to try to attract and retain those physicians.

There's a section in this bill that says that the minister now will try to get them to—first of all, the minister must approve every one of those arrangements. There are 22,000 physicians in the province and there are probably, I'm told, close to 14,000 different arrangements out there. We were in northern Ontario yesterday, for example, and here in eastern Ontario with shortages. Outside of alternative plans—you told us you get nothing to be president—do you have colleagues who are in any way aware of this? Secondly, if they are aware, are they apprehensive about it?

Dr Beck: I think that all of my colleagues are apprehensive. This is certainly not the first government to suggest that doctors ought to be forced to practise in certain parts of the province. Our medical students and our medical graduates are the best in the world. They can travel anywhere on the credentials they earn in this country.

In many cases, what we know about medical students is that if you have enough medical students from a community like yours or smaller communities in any part of rural Canada, the students from those communities are more likely to return to those communities. The recommendations of medical schools have been that you have to recruit medical students from all parts of the country in order that they'll return.

When I sat on the committee on health human resources several years ago, what we learned was that 50% of the medical students in Ontario, no matter where they went to school, were from metro Toronto. It's no wonder that's where they want to practise; that's where they're from. If we want physicians to practise across Ontario, we have to go to Sault Ste Marie and Thunder Bay and recruit physicians there. Then they'll return to where they are from or to very similar communities, because that's where they grew up.

The Chair: Ms Martel, you have seven minutes.

Ms Shelley Martel (Nickel Belt): Thank you, Dr Beck, for being here this morning. You mentioned in your remarks that you heard the minister say there were going to be amendments, and you're pleased about that. Given all we've heard to date, I do wonder how we even got here with the particular bill we've got before us right now, because with the exception probably of one presentation yesterday that was fairly supportive, the rest have

been fairly to very unsupportive. I'm not sure that amendments can fix this. I'm starting to wonder whether or not the whole thing doesn't have to be withdrawn and the minister start again.

Let me focus on the council. Before that, let me say that I appreciated your remarks that said, "Where is the accountability for the government with respect to the health care system?" and ensuring that people have access and that waiting times, for example, are dealt with.

This brings me to the function of the council. On Monday the minister suggested that one of the mechanisms that makes him accountable with respect to health care will be the council. I differ with him on that, because frankly I don't see that the council has much of any responsibility that the minister will have to be accountable for.

In the bill as it's presented, the group doesn't even make recommendations about the health care system; they can only make recommendations about what they report on. Right now their functions are to monitor and to report; nothing about making a recommendation with respect to what they found. That concerns me, because what will then force the minister to respond?

You mentioned wait times. The example I've been using is that Cancer Care Ontario, as early as 1999, was suggesting that optimal waiting time, the benchmark they're trying to work toward, is four weeks for someone to start cancer treatment, and they're not meeting that. They're not the only group that is not meeting wait times. Even if the council was to report on that, they can't make recommendations about what the minister can do or should do about that with respect to funding etc, nor can they make recommendations about changes to health policy, health laws etc.

You sat on a group that made recommendations. I don't know where they went. My concern is, we're going to have yet another group that gives a report about the state of health and nothing happens from there.

Dr Beck: It would be difficult to know what happens with some of these reports. Certainly the Ontario health council is very similar to a recommendation made by the George report for a body to oversee some of the things this council is going to see. As a citizen of Canada, you do see that there are lots of reports requested. As well as the George panel, I'm also presently involved in the technical advisory committee on the disability tax credit.

One of the things you see is that ministers themselves become, I guess you could say, attached to their committees. They pick people who they think can do a reasonable job, they see the work they do, they see that they're trying to work very hard to get good, timely recommendations, and they know themselves that there are political pressures on recommendations that may not be in keeping with what their government wants. But I genuinely think that when ministers look for recommendations from committees, for the most part they want to be able to put in place the recommendations of those committees.

This seems to be, in many respects, an entirely cynical bill. When you read through it, there is phrasing and tone that really suggests there isn't a lot of goodwill between the government of Ontario and the people of Ontario and between the government of Ontario and the physicians and health care providers of Ontario. I don't believe that to be the case. I have worked very closely at times with Richard Patten. I know who he is. I know what he believes in. It doesn't seem to be reflected in this kind of bill. It's very hard to believe that this bill actually passed through the minister's office, in my view, because it's so cynical in the way it looks at relationships that we know have been reasonably strong. Hopefully it's something that will be remedied.

1000

Ms Martel: I know you're very busy, so I'm not sure how much time you had to do all this. If you look at the preamble, it has really glowing statements about medicare, which are motherhood statements. For goodness' sake, of course we support medicare, in this of all countries. If you look at the statements, that this bill is going to essentially confirm Ontario's commitment to the principles of public administration, comprehensiveness, universality, portability, accessibility, that we're going to prohibit two-tier medicine, and then you look at the details of the bill with respect to where the funding is for home care, where the funding is for pharmacare, do you see provisions in the bill that actually support the preamble, that actually are going to enhance medicare in the province?

Dr Beck: This government right now has a unique opportunity to do something to ensure the sustainability of the health care system in this country. Our health care system has been the envy of the world. Commissioner Romanow, Senator Kirby—we have reports coming out our ears with suggestions for how the system can be changed. The physicians of Canada themselves and the physicians of this community support those views and are ready to work toward a sustainable health care system in this country. The physicians of Ontario are prepared to work with our government, with the council of federations, in order to ensure sustainability of this health care system. We're committed to it. We've been working in it for a number of years. We work extra hours in it.

We would like to see in this bill some statements by the government of Ontario of how it's going to work with the Romanow report, with other provinces, with the people of Ontario to set up care guarantees; how it's going to work with different communities to recruit young physicians, to ensure that they have the residency spots they need to train when they're finished medical school. There is nothing about any of these things in this bill.

The Chair: I'm going to the Liberals now.

Ms Kathleen O. Wynne (Don Valley West): Thank you very much for being here today. I just wanted to make a couple of comments and then I think some of my other colleagues have questions. I don't know if you had a chance to get a copy of the minister's remarks from yesterday.

Dr Beck: I did not.

Ms Wynne: OK, we will get a copy of those for you. You talked about the tone of the bill, and I think it's important that we acknowledge that we think we got the tone wrong. The minister has said that. There are definitely changes that need to come and we need to address that tone. When I hear you speak, it sounds as though you're seeing this bill as an attack on individual physicians, and that is certainly not the intention in any way. So I'll make sure you get a copy of the remarks.

I wanted to address a couple of your other concerns. You talked about subsection 17(2) in the accessibility section. The minister has talked about adjustments needed there, so there will be amendments coming forward to address that concern.

You also talked about concerns in the accountability section. I guess I wanted to ask you whether you have a concern that the accountability measures put in place—and they're not very specific. They need to be more specific, and they will be, as the bill evolves. One of the things we need to remember is that this bill is out after first reading, so there are a number of other opportunities to work on it. That's also part of our strategy, to do consultation early on in these pieces of legislation so that we get them right.

Around the accountability issues, is it your fear that individual physicians are going to be held to account in a way that they're not now? The intention of the bill is that the accountability provisions will apply to a broad range of publicly funded organizations. We understand that doctors are already accountable for their clinical standards and the OHIP requirements. Can you just talk about your concern there a bit more?

Dr Beck: I do have concerns when I go through it that physicians in this community, and other health care professionals as well as non-professionals, contribute in a number of ways to health care through their volunteer work. We're dependent on that volunteer work. In addition to that, because that work is voluntary, in a way, we know that some of the people who step up to do it want to do it for the kinds of reasons that come from our best inclinations and not from those that are influenced by financial gain.

I don't understand why the accountability section of that, when there are concerns about accountability in other ways that we're worried about, is emerging in this bill. I guess I could say that maybe it goes back to the tone. I don't know why, coming right out of the gate, when you look at the relationship that most people in this province have with their physicians, with the nurses who treat them, even in their communities if they feel they have to present to the boards of their hospitals—we have good working relationships. There's no need for this tone in this bill.

Ms Wynne: Right. If we can find a way to address the tone, I think what this comes out of is a general sense that we're putting millions and millions of dollars—when I say "we" I mean the whole society—into health care and there's a sense that we don't really know where it's going

and we don't really know what the practices are. What we're trying to do is to bring some clarity to that. In talking about these accountability agreements, if the government has some standards, some goals in place, and builds a framework around what health care should be delivering and then enters into these agreements with organizations and there's a discussion that goes on, I guess that's part of what needs to be laid out in the bill: What's the process whereby the accountability agreements are put in place? Would you agree with that, if there was more clarity there?

Dr Beck: I would agree with that. I would also agree that those things have to be a little bit of a two-way street. It's one thing to say—because some of this stuff is best guesses. We have some good evidence-based wait times. We have some idea of how long is too long to wait for a hip replacement, how long is too long to wait for a psychiatric consultation. We have that kind of evidence. Even physicians don't agree that the only way to solve a problem is to throw money at it. You have to consider not only the investment, but which are the parts of the investment that are going to pay back what you really want.

Ms Wynne: So in putting those agreements in place there has to be a solid discussion between the government and the—

Dr Beck: Yes, and an ongoing dialogue. If I see someone in my office and they're not well and I say, "I think maybe you should have some psychotherapy from a social worker; I think maybe your family ought to do this or that," I don't make that recommendation and say, "Come back in three months to see what's happening." There's an ongoing dialogue about whether or not they feel that's needed. That's how health care works. There are ongoing dialogues between health care providers and their patients. This bill looks as though, all of a sudden, we'll just throw in some government here and see if that works. There is evidence in this country for how government best works in the system.

Ms Wynne: Am I out of time?

The Chair: Yes, you are.

Ms Wynne: OK. I just want to reassure you that a number of the things we've talked about are going to come forward in amendments. If we don't get the tone right, this won't work. It is certainly our intention to do that.

Dr Beck: It's not only the tone; it's what behind the tone and why that tone emerges, but I thank you for that reassurance.

Ms Wynne: We'll get the copy of—there it is.

The Chair: Thank you, Dr Beck, for coming today. We certainly do appreciate your input. Thank you for taking the time.

1010

DENNIS PITT

The Chair: If I can now call forward the representative from the Ontario Medical Association, the Ottawa chapter, Dennis Pitt.

Dr Pitt, same rules as I outlined before. You've got 30 minutes. You can use that any way you choose. At the end of your presentation we'll share the remaining time amongst the three parties.

Dr Dennis Pitt: It's a pleasure to be here, ladies and gentlemen, and to have the opportunity to make some comments about this bill. I'm a general surgeon. I have practised in Ottawa for more than 20 years. Currently, I practise at the Ottawa Hospital. I'm an assistant professor of surgery at the University of Ottawa. I'm a member of the academic alternate funding plan at the Ottawa Hospital, which currently is in phase one.

I serve some executive functions at the Ottawa Hospital: I'm vice-president of the medical staff association, a member of the board of governors of the hospital and a member of the medical advisory committee and several other committees at the hospital. I receive no payment from the hospital or from the ministry for those executive tasks. I get a small stipend from dues that my colleagues, other doctors, pay. Almost all my income comes from clinical care, looking after patients. I make those remarks so you'll understand my concerns about the accountability provisions of this bill with respect to executive functions in the hospital.

I firmly believe the system of medical care we have here in Ontario is the best in the world. If I got sick in any other country besides Canada, my first concern would be getting back to Ontario. If I got sick in any province other than Ontario, my first concern would be getting back to Ontario. I think we have the best there is.

That's not to say there's no room for improvement. There certainly are areas that are not perfect that I would have liked to see Bill 8 address: the shortage of physicians; doctors leaving the hospital, not infrequently, because of a lack of resources to look after their patients; as a surgeon, the long waiting lists are a day-to-day concern that I have to face; on the hospital board, I hear at least every month about funding that's unpredictable and difficulties knowing what our budget is.

I'm speaking to you today not as a board member from the Ottawa Hospital, not on behalf of any medical organization or the university; I'm speaking to you as a practising surgeon in private practice here at the Ottawa Hospital. So my remarks are not the official party line from any organization.

When I read this bill, the preamble was wonderful. It's great. I support it entirely. Obviously, whoever drew up this bill, the people behind it, the minister, have good intentions. Their heart is in the right place. They mean well. However, there are some things in the bill that obviously have not come out right. They mean well, but the effect will not be what they intend. I'll comment mostly about accountability, and I'll make a brief comment about annual fees for uninsured services.

Sections 21, 22, 24 and 27 concern accountability. I have no legal background, so I don't pretend to have expertise in reading this type of bill. However, I read these sections several times, and what they mean to me is that health care providers such as myself can be forced

by the minister to sign an accountability agreement for their executive duties and the minister can change it unilaterally or terminate it, and the health care provider is deemed to agree.

I read that several times, and to me this doesn't talk about an agreement. This is not an agreement. The word that comes to mind is "dictator." I can't imagine that I would ever enter into an agreement where somebody can dictate those types of terms to me and I have no say in the matter. As I said, in my positions I'm not employed by the ministry and I'm not employed by the hospital. I do what I do because I want to do it. I think I'm making a significant contribution. My colleagues elect me to the medical staff executive, and certainly the money is not a factor. So why I would enter into an agreement where I can be dictated to on these terms is unimaginable to me.

The second problem with these sections, as I read them, is that the minister can deem that I agree to any changes in the accountability agreements. When I read that, the word that comes to mind is "perjury." The minister can force me to perjure myself, saying that I agree to something when I don't. Obviously, I would never put myself in the type of position where anybody, including the Minister of Health, could have that power over me.

In section 31, under accountability, if I fail to comply with the accountability agreements that I'm forced to sign, I put myself at risk of a \$100,000 fine. I have a wife and four daughters. They're all in school. I haven't paid for their education yet; I haven't paid for any weddings yet. For me to submit to a situation where I'm at risk of financial bankruptcy is just impossible. These provisions read more like a master-slave relationship. I know it's a very serious thing here this morning and I don't mean to be flippant, but it's almost slapstick humour when you think I would voluntarily get myself into that situation.

I don't want you to get the impression that I don't support accountability. Surgeons in Ontario probably have more accountability provisions than anybody else in this province. I'm accountable to my patients; to the royal college to maintain my specialist certification; to the Ontario college for my licence, standards of practice, discipline and quality audits; to the Ministry of Health medical review committee; to the legal system, lawsuits, coroners; to the hospital practice peer review. I'm surrounded by accountability, and I think it's a very good thing.

Unfortunately, the effect of the accountability provisions in this bill is not to increase accountability for physicians in executive functions; what they do is stop all physician participation on hospital committees, as heads of departments, heads of divisions, chiefs of staff, presidents of medical staff. No physician would ever put himself in this type of liability to carry out those functions. They'll cease all those activities. Physicians will continue to look after their patients, but that's all. They'll contribute nothing else to the hospital.

The final thing I want to comment on—and I'll be very brief—is section 16, about annual fees for uninsured services. As a surgeon, I don't have long-term patients. I

see patients on referral only. So when there's an uninsured service to perform, such as signing a sick note or filling out an insurance form, the patient pays me \$10 or whatever and I sign the form. And if they don't pay me, I don't sign the form. Granted, if I perceive they have financial difficulties—they're indigent or something like that—I don't charge them. But by and large they just pay me when I perform the service. I don't give them the option of paying annually for uninsured services, as some family doctors work out with their patients. It's not clear to me why the minister is interested in uninsured services that are provided.

When I read section 16, there's the threat of a jail term for physicians. Threatening my profession, threatening me with a jail term, is very offensive. It implies that we're part of a criminal class—motorcycle gang members or something. We have a problem with doctors leaving Ontario, and this provision will certainly encourage a lot of doctors that Ontario is not a very friendly place to practise.

Most of my remarks have been critical, but I have recently been told that Mr Smitherman and the Liberal government are looking at revisions to this bill. I hope these remarks and criticisms can be taken as constructive. I look forward to seeing a bill that follows through on the provisions in the preamble, and that the mechanics match the good intentions.

Thank you very much for listening and for the opportunity of speaking with you.

1020

The Chair: That took 11 minutes, which leaves 19, so we'll go with six minutes each and start with Ms Martel.

Ms Martel: Thank you for coming to speak to us today. You said the effect of the provisions will be to stop all physicians from being involved in executive positions in hospitals. Yesterday we heard very strongly from a number of board members that none of them would be around either, so we're going to have a lot of people fleeing the health care system before this is finished.

I ask you this question not to try to put you on notice or to undermine you in any way—and I asked it of the last group of presenters we had yesterday, who were a number of CEOs and volunteers: In all your capacities, although I appreciate the one in which you're speaking today, can you see any reason why the Ministry of Health and the minister would put this kind of bill with this kind of tone and language on the table? Do you see anything in the hospital, anything among your colleagues, anything in the work you do that would encourage a bill that has such draconian provisions for the minister and a tone that would just promote confrontation?

Dr Pitt: The simple answer is no. I don't think there is anything we've done to provoke it. My own view is that the minister's intentions were good; it's just lack of information about what actually happens in the hospitals and how we interact that has led to this bill, and it certainly needs to be corrected.

Ms Martel: I appreciate that you say "lack of information," maybe on his part or a lack of information being

transmitted to him about the workings of the system. But you don't have to know too much about the workings of the system to know that a response, in terms of the minister's powers here, which are really overwhelming, is like taking a sledgehammer to some kind of problem that you perceive to be in the system, and we haven't figured out yet what problem the minister perceives.

If I just look at some of the powers—it's probably worth reading a few of them into the record. If you look at the compliance directives, for example, in section 22: "The minister may at any time issue a directive compelling a health resource provider or any other prescribed person, agency or entity to take or to refrain from taking any action that is specified in the directive or to comply with one or more of the prescribed compliance measures."

If you look at section 24: "The minister may at any time terminate an accountability agreement or a compliance directive, and may at any time vary a compliance directive or issue a new compliance directive."

Section 26, consequences: "Where, in the opinion of the minister, any person, agency or entity described in section 21 or 22 fails to enter into an accountability agreement, fails to comply with any terms of an accountability agreement or fails to comply with all or any part of a compliance directive, the minister may make an order providing for one or more prescribed measures."

The powers of the minister are overwhelming in this bill. "Draconian" is probably the appropriate word to use. I just can't see how a lack of information transmitted to him about how the system works could have resulted in the kinds of measures we see outlined here.

Dr Pitt: I don't know why these measures have been brought forth either. I certainly can't answer that.

Ms Martel: If you look at the penalty provisions—and earlier you used your own personal situation in terms of four daughters at home and none of them married yet and no weddings paid for. That's your particular situation, and I'm going to assume that's the situation of most other physicians or surgeons who would be having some kind of executive position. No one is going to want to have that liability hanging around their neck.

Dr Pitt: That's correct. That's too big a risk to run financially for what we do.

Ms Martel: So unless this is dramatically changed, you would see a number of people just resigning outright from the important positions and the important work they're doing on hospital committees now.

Dr Pitt: Correct.

Ms Martel: You talked about the preamble, and I just want to go back to that for a moment. I'll ask you a question that I also asked your colleague who came before you. Who could not support the provisions in the preamble? Who could not support the statement of Ontarians' support for medicare? I look at the preamble, and then I go to the bill and see a lot of talk about accountability. I see nothing, though, that says what the government's role and accountability will be in terms of ensuring, for example, that funding is in place to support

what we want in medicare or that, as Romanow suggested, we're going to have pharmacare in the province or, as even the preamble suggests, we're going to do something about home care to ensure that that's covered under the Canada Health Act.

Do you see, as you move from the preamble—which is a great statement—to the guts of the bill, anything in the bill that is actually there to either support or enhance medicare?

Dr Pitt: No, I didn't see anything positive about this. Accountability in this bill is entirely on the backs of the health care providers. I would certainly like to see something about government accountability in here as far as referring to waiting times or hospital resources or any number of things that they could have taken on as a responsibility for themselves.

Ms Monique Smith (Nipissing): Thank you, Dr Pitt, for joining us today. I really appreciate your comments and the concerns that you've raised. I think some of them have been addressed by the minister in his opening statement. I don't know that you've had a chance to see it, but I'll make sure that you have a copy before you go today.

In his opening statement before this committee on Monday, he did state that he felt he had the tone wrong in this bill and that we are working toward improving that and certainly improving the entire bill.

As my colleague noted in the previous presentation, this bill is being brought forward after first reading, which is an unusual step. We're looking for a lot of public input, so we appreciate your coming forward with your concerns. We hope to be able to calm some of those concerns and also get some more information from you so that the amendments we bring forward will make this a better bill and will really fulfill the intentions of the act.

You had concerns about accountability with respect to the executive function. Let me just say that the health care providers that are intended to enter into accountability agreements in this legislation were designated or listed by the minister in his statement as hospitals, CCACs, long-term-care facilities and independent health facilities. He went on to state, "The bill does not apply to solo physicians, group practices or labour unions. We will offer amendments that make that abundantly clear." That's just to calm your fears that the accountability agreements will not apply to practitioners like yourself.

I recognize your concerns about the shortage of doctors in our communities. I'm from northern Ontario so I'm fully aware of that need and, of course, of long waiting lists. That's another concern that we as a government hope to address over the next four years. The unpredictability of funding is a concern that I think is being addressed as we negotiate multi-year funding agreements between our hospitals and the ministry. I know that that work is ongoing. I appreciate your raising those and I want you to know that we're also very cognizant that those issues are outstanding.

You raised a number of specific concerns. One was with respect to leadership in the hospitals and those who would be part of performance agreements. I think the intention of this legislation is to designate those

performance agreements specifically between a CEO and a board. The accountability agreement would be between the board and the ministry, and then there would be a subsequent performance agreement between the ministry and the CEO that would reflect that accountability agreement. I don't think the roles that you're playing, and that we appreciate that you play in your hospital, will be affected in any way by this legislation.

You talked a little bit about section 31 and the fines there as being harsh. I had to chuckle when you talked about your four daughters and their weddings. My brother is getting married this weekend so a wedding is very much top of mind, as my colleagues have heard me talk about this week. So I appreciate that. We have heard that message.

As you no doubt are aware, the ministry and the minister himself have been in discussions with a number of stakeholders from the first reading of this bill up until these hearings started. Certainly in our discussions with the OMA we've heard about the concerns surrounding that. I think you'll see amendments around the fines, the penalties, the harshness and the incarceration. That was part of what the minister was trying to address in his "tone" comments and I think you'll see some amendments there that will satisfy you in that regard.

I was pleased to hear that you support the notion of accountability. I'd just like to expand on that for a moment and ask you, are you supportive of the notion of accountability agreements between hospitals as we foresee it now through boards and the ministry? Do you think that's generally a good idea?

Dr Pitt: Yes, I do support that. In our alternate funding plan for the academic centre, there are accountability clauses, for primary care reform there are accountability clauses, and I am fully supportive of that.

1030

Ms Smith: Great. I also just wanted to ask you briefly about your comments on block fees. I understand that you don't have that experience in your practice and you've raised a question as to why that would be raised in this legislation.

I think one of the concerns out there is that while we hate to, in effect, legitimize block fees, they are in fact in place in a number of practices and we are hearing of situations that we are very concerned about where block fees are being charged, \$2,500 a year, and are seen as kind of key money in order to secure a family physician. Because of the shortage, there's some jockeying. So we're concerned about that and we want to make sure that, within the framework, health care is accessible to everyone and that these fees aren't prohibiting someone from accessing health care.

I just wondered if you had any other thoughts or ideas. We're really looking for direction on this one as to how we could structure something that would allow physicians the flexibility they need but also address our concerns about accessibility.

Dr Pitt: Excessive fees charged annually for non-insured services are wrong and I would not support that.

The College of Physicians and Surgeons of Ontario currently regulates block fees. They have a number of provisions for it. I'm not familiar with them, because I don't charge them. The college, in my view, does a very good job of regulating physicians in Ontario and I think working with them and making the provisions adequate to handle the concerns that you have representing the public would be the process of solving this problem.

Ms Smith: Oh, I'm out of time.

The Chair: You are. Mr Klees.

Mr Frank Klees (Oak Ridges): Thank you, Dr Pitt, for your presentation. I think you are joined by probably everyone in the health care sector across this province in your consternation about this bill. The encouraging thing, or discouraging thing, is that you're joined by the Minister of Health himself. In his opening statement to this committee he seemed to reveal that either he had not read the bill before he came to committee or he read it and didn't understand it, because he was clearly embarrassed at what he was reading. He was clearly embarrassed at not only the tone—he referred to the tone—but clearly was embarrassed by the structure as well, because he gave directions to his parliamentary assistant to assure everyone that there would be wholesale changes to this bill.

I think one of the key issues that we have heard time and again, regardless of who the stakeholders were—we've heard from medical doctors, nurses, labour groups, the volunteer sector—whether they be boards of trustees or others, there's a consistent theme here. Never before have I been in a committee where everyone condemns the bill.

So from that standpoint, we have a problem as a committee. We should be hearing recommendations in terms of how to make it better, but the underlying theme is that really this is so bad that there's not much left to breathe life into it.

A fundamental concern is the absolute disregard for contract law that I think reflects not only on this bill but on this government. In your particular case, you refer to it. Sections 27 and 28 concern many people, whether they're medical doctors who have entered into agreements—and there are many agreements that physicians enter into with hospitals and various other organizations—or whether it's an association, but the issue is of the Minister of Health having the absolute authority to set aside those agreements and, according to sections 27 and 28, you as the recipient not being entitled to any compensation for a setting aside of that agreement. It goes for you as a medical doctor; it goes for a CEO who may have an agreement.

Certainly on this side of the House we feel very strongly that there are some fundamental principles here that have to be addressed, or, as was said previously, we won't have anyone in health care in this province at the table.

I'd be interested to know how you feel about this. Our recommendation is that, given the preamble and all of the good things that are said there and the absolute dis-

connect between the preamble and what the bill says—it must have been two different sets of people drafting, because the one obviously didn't know what the other was doing—the best thing to do is to scrap this bill, set it aside, and go back to the Minister of Health and say, "You had the preamble right. Now, would you please draft a bill that's consistent with that, that sets aside all of these other concerns?" How would you feel about that?

Dr Pitt: That sounds reasonable to me. I think the important thing is that some health care providers who are what we call "on the front lines" have some input here, and that specifically doctors should be consulted and involved in the drafting of these types of bills before they come to first reading.

Mr Klees: On that note, Chair, I do have a motion that I'd like to put forward for consideration by the committee. I can do that now or I can wait until after this deputation.

The Chair: This deputation is over in 10 seconds. Dr Pitt, I want to thank you for your time.

Mr Klees: In that case, I'd like to do it now.

The Chair: And you have it in writing for us, Mr Klees?

Mr Klees: I do.

The Chair: Very good. You're going to read it into the record, then, Mr Klees? After that, can we get it to one of the clerks to get it copied so that all members have a copy?

Mr Klees: I'm happy to do that. I move that whereas the committee has heard from stakeholders representing the broadest possible scope of health care professionals and volunteers engaged in the governance structure of health care delivery in the province; and

Whereas deputations to the committee have been heard from stakeholder groups representing medical doctors, nurses, social workers, representatives of boards of trustees, hospital CEOs, labour councils, as well as consumer representatives, all having unanimously condemned not only the tone but the fundamental premise of this bill; and

Whereas the minister himself has conceded that the bill is flawed, and the repetitive insistence on the part of the parliamentary assistant to the Minister of Health that wholesale changes will in fact be made to the bill; and

Whereas those amendments will in fact result in such substantive change to the bill that the very basis of the bill may well be overturned and therefore be found not to meet the requirements of the Legislature's standing orders;

The committee recommend the immediate withdrawal of Bill 8.

The Chair: If we can call a brief recess, we can get that photocopied. We'll recess for 10 minutes.

The committee recessed from 1040 to 1050.

The Chair: Mr Klees, as the clerk was photocopying your motion, they reviewed it and have informed me that it is out of order. The proper procedure would be to either vote for or against the bill. That's within our powers, obviously. We don't have the option to withdraw the bill

as a committee or as individual committee members. We can vote for or against the bill, and that obviously takes place during clause-by-clause, which starts on March 9.

Mr John R. Baird (Nepean-Carleton): On a point of order, Mr Chair: Thank you very much for the opportunity to make a point of order. The motion itself doesn't call—I recognize you're very correct in your decision—for the committee to withdraw the bill. The motion simply is a statement of the wishes, the desires of the committee to the government, to the minister, that we are recommending. You're very right, we can't withdraw it ourselves, but the motion drafted by my colleague Mr Klees merely makes a recommendation to the minister.

I think procedurally doing that, the minister himself in his statement the other day and then the parliamentary assistant and other members of the government have indicated that substantial motions will be coming forward. I know, in addition to the reasons outlined by my colleague from York region, the deputants who are coming before us won't have the opportunity to give public comment on those amendments.

Simply put, I recognize we can't withdraw it, the committee doesn't have that power to withdraw it, but we could certainly recommend that the minister and the government—the executive council, the executive branch of government—take the advice of this committee. That's their decision.

The Chair: The advice I'm receiving is that the bill cannot be withdrawn. We'd be recommending something that could—

Mr Baird: I realize we can't withdraw it. We would just simply make a recommendation to the executive branch.

The Chair: But the bill cannot be withdrawn in any event. It's got to be voted for or against.

Mr Baird: No, if we made a recommendation to the minister, he could talk to his colleagues and say, "You know what? You're right. It's unfair to the presenters to come forward and make presentations any more in the absence of the amendments with which we're going to deal with all of their concerns. Gee, I appreciate the advice of the committee, and I'm going to recommend to the committee that they cease their hearings, and when the House comes back on March 22, that we would withdraw it." It's a recommendation. Obviously, we can't withdraw it in this committee. I recognize that. We can't vote to withdraw it, but we can just give a recommendation as a legislative committee to the executive branch.

The Chair: OK, the advice I'm receiving from the clerk is that that is out of order and cannot be done.

Mr Baird: Why? I don't mean to challenge you—you're just passing along—

The Chair: No, no, I appreciate this, because I do want to do this correctly.

Mr Baird: I appreciate your willingness to entertain the discussion. We can hear from the clerk, it's fine.

Ms Smith: Just make up the rules as you go along.

Mr Baird: Oh, you're an expert in the rules three months into the job, are you?

The Chair: I'm trying to listen with one ear.

OK, I've conferred with the clerk again. We have a few alternatives. One of those is not to recommend the withdrawal of the bill. We can report back to the House, obviously. We can choose to not report back to the House. We can report the bill back, as amended. We can report the bill back with no amendments, or we can not report at all. But we could not make a recommendation that the bill be withdrawn.

Mr Baird: I agree with you. I accept that. I accept your ruling. Could Mr Klees move a motion requesting that the committee halt its hearings and report the bill without amendment back to the House?

The Chair: During clause-by-clause, but by then, obviously, the hearings would be over.

Mr Baird: We couldn't report it back now, seeking to amend the subcommittee's report? I just think it's unfair to the people who are making presentations to offer—

The Chair: OK. I think there's a way of achieving what you would want to achieve. If the committee was prepared to go into clause-by-clause right now, it could do that.

Mr Baird: Thank you.

Mr Klees: I think it's important that the intent of this motion is fully understood by the committee. I wouldn't challenge the ruling relative to the point that has been made; however, I do believe there may be another alternative here, and that is that the committee communicate with the minister that this motion has been made and to allow the minister then to make a decision, based on what the committee has found, to act on it or not to act on it. I would ask that at least we consider doing that. I think it's important, Chair, that we, at the earliest possible opportunity, communicate with the minister the gravity of this situation.

I'm the first one to say, yes, let's consult. But we have had a very clear expression so far that this committee is effectively wasting taxpayers' dollars by taking a bill across the province that is so fundamentally flawed. Let's conduct hearings on the basis of a bill that at least is substantive and that people can embrace. That's my intent. So if we can at least agree—

The Chair: I think that will probably happen as a matter of course. I've ruled the motion out of order. It's not debatable, but I did want to explain the reason for that. I think the fact that you have made the motion is probably on the news. It definitely will be getting back to the minister in some form. To ask for the committee to report to the minister on a motion that was ruled out of order I think procedurally would be incorrect. I haven't been here a long time, but news seems to travel pretty quickly from building to building. I suspect that's going to happen in this case. So on that, unless you've got another point of order—

Mr Klees: I do. I would ask, then, not necessarily that you do, but I certainly would ask that the clerk ensure that the minister is apprised and receives communication of this—let me put it this way, because I see you getting some advice and some shaking of the head. Let me pre-empt that.

Ms Smith: Mr Chair, maybe I can pre-empt this by saying that I will undertake to advise the minister of Mr Klees's concerns and of the fact that he brought this motion. Would that satisfy you and can we return to the presentations?

Mr Klees: Would you be willing to do that in writing and present me with a copy of that?

Ms Smith: Of a letter that I write to the minister, or of my undertaking?

Mr Klees: No, of a letter that you write to the minister advising him of this motion.

The Chair: There we go.

Ms Smith: I can call him.

Mr Klees: Would you be willing to do that in writing?

Ms Smith: Mr Klees, if it will allow the presenters who are waiting to present, yes, I will put it in writing.

Mr Klees: Thank you very much. I appreciate that.

The Chair: Everybody's happy again—I thought. Mr Baird.

Mr Baird: I appreciate that you're doing an excellent job. These issues are very complex.

I have a question for the parliamentary assistant. Would she be willing to table the amendments to this bill for 30 days just to allow all these presenters to see the amendments rather than—we'll be back in Toronto—

Mr Khalil Ramal (London-Fanshawe): Point of order, Mr Chair: We are here to listen to different presentations. We have a busy list. We're not here to debate. I would rather listen to the people and then take their consultation instead of debating among us.

The Chair: I tend to agree with you, Mr Ramal.

Could you summarize in 20 seconds what—

Mr Baird: Sure. I just want to know—there are a lot of apologies to the presenters that the bill is terrible and we're going to fix it. Would the presenters all have an opportunity to see the amendments to fix it before we vote on it? We're basically going to gut the bill, and I want these folks who have come here to be able to see the fix-it before we vote on it.

The Chair: We'll get you an answer on that before the end of the day, Mr Baird.

Mr Wilson: Just a quick point of order that I believe is a point of order: The minister made a commitment on Monday to present within 72 hours a draft outline of the amendments that he was considering, and we haven't been presented that today.

Ms Smith: It's only 48 hours now; 72 hours would be tomorrow morning.

Mr Wilson: Today is Wednesday, isn't it?

Ms Smith: We started on Monday.

Interjection.

Mr Wilson: OK, "within." So is it coming tomorrow?

Ms Smith: You'll have it within 72 hours of when the minister made the commitment, which was 1 o'clock on Monday.

Mr Wilson: OK. It's appreciated.

The Chair: Thank you all for your patience and co-operation. I believe we're back on track—not that we were ever off track.

1100

CAPITAL HEALTH ALLIANCE

The Chair: Now we are going on to the Capital Health Alliance, who are represented by Tom Schonberg from Queensway-Carleton Hospital and Jeff Polowin. Alasdair Smith is not here today; is that correct?

Mr Tom Schonberg: That's correct.

The Chair: Very good. I'm not sure if you were here at the start of the day. You've got 30 minutes to use as you see fit. At the end of your presentation we'll split that time amongst the three parties equally.

Mr Schonberg: Sounds good. Thank you very much. Obviously, we have heard a number of the presentations. You will hear a lot of the same information. But first of all, I'm here representing the Capital Health Alliance, which is essentially a voluntary amalgam or association. All the health care providers in this region are represented, so it's the hospitals, the community care access centre, public health, the district health council, etc.

We support, basically, the government's commitment to medicare and the key aspects of the bill, the adoption of the five principles as well as the inclusion of accountability. As has been said many times, the preamble in the bill is good. The rest of the bill, though, does not fit.

Specifically, what doesn't fit? When the bill talks about accountability, the way it's drafted, it will undermine community involvement and certainly the involvement of local voluntary governance for public hospitals across this province. Revisions don't provide for shared accountability, and by any definition of accountability by any management guru or practising management authority, it has to be shared. In other words, providers and government have to have a dual accountability framework or agreement. It has to be negotiated. Otherwise it's a directive and nothing else.

The bill also speaks to the tenets, if you will, of medicare, but it is silent with respect to accessibility. In other words, this government took power and recognized that we had major issues as far as wait times and there is nothing in the bill that, specifically in the accountability, addresses or makes a commitment by government to address accessibility and wait times.

Being a little bit more specific, and many of you have already mentioned this, in the bill sections in the 20s—they are numerous: 26, 27, all the 20s series, essentially—the way the bill is drafted, it is directive. It is one-way. It really will turn the boards into advisory boards. My board chair is here representing, as an example. Board chairs will speak to that further. Obviously, if you have a bill that enables the minister to change the relationship with a CEO—and the CEO, as well as the board chair, are the only two people the board has the authority to hire and fire. They look to us to run the hospital and to hold us accountable. But when you take that authority potentially away, as this bill would do, it would make someone like myself really like a civil servant, if you will, or a bureaucrat, yet it undermines any protection that I might have as part of the bureaucracy as well.

You've heard that before. You will lose a lot of talented people, not only from boards but from management, because really you're in an untenable situation.

The government also was quoted from the Ontario speech from the throne in November saying that "Your new government understands it can only hold others to a higher standard if it subjects itself to the same standard." That's, I think, one of the premises in this bill that is not addressed: about the dual accountability.

One of the other aspects that I think is critical, which I'm not sure you've been made aware of, is that a similar type of arrangement exists in British Columbia. The auditor general very specifically stated that these accountability agreements or performance agreements must be made between hospital boards and the government. It is up to the CEO, the chief of staff and, on the government side, the deputy and the rest of the bureaucracy, to actually implement. I did hear the previous presentation, and I'm very well aware of that. I sit on behalf of the OHA on the provincial task group that is looking at Bill 8 and that is also working with the government to come up with a performance agreement for all hospitals across this province.

Our concern is that it may be said that the minister does not want to undermine voluntary boards, but it has been said before that unless you scrap the major parts of this bill that essentially provide a directive relationship between the minister and the CEO, you will still undermine the board, irrespective that you say the intent is not to do so. My colleague will speak to the fact that in doing that you will undermine a check and balance we've had in existence for many years between community representation on one hand, which looks after community interests, and government interests, which often, realistically, are focused on resource conservation or resource allocation. Jeff?

1110

The Chair: I'm sorry, I didn't ask you gentlemen to identify yourselves. I introduced you, but—

Mr Schonberg: I'm Tom Schonberg, CEO of Queensway-Carleton, and I'm also representing Capital Health Alliance.

The Chair: Just for Hansard, would you identify yourself as well?

Mr Jeff Polowin: My name is Jeff Polowin. I'm the chairman of the board of Queensway-Carleton Hospital. In my 9-to-5 life, or lately it seems like my spare time, I'm the senior vice-president of a major public affairs firm. Since assuming the chair's position at the QCH in June of last year, I've spent more than 400 hours, travelled more than 4,000 kilometres, have been out at umpteen night meetings when I could have been at home with my wife and spent countless hours on the telephone. It's not about me; I'm not alone. There are hundreds of people like me across the province.

Why do we do this? I can only speak for myself. I do it because this community has been good to me and to my family, and I want to put back. I want to play a role in ensuring that people in our community receive the health

care they want and deserve, and I want to know that the hours I'm putting into this make a difference.

I honestly believe that if you pass this bill the way it is written, I will not be making an impact. I believe that I, and people like me, will become figureheads. I believe that the only people who will be board members in the future are those who want to put board membership on their resumés. And believe me, you don't want those people.

I've canvassed the members of my board. They're lawyers, accountants, public servants and consultants—busy people who have made this commitment to their community—and they've all told me that if this bill passes the way it is written, they're gone. They don't want to be figureheads; they don't want to be rubber stamps. They want to make a difference. Those lawyers, accountants, public servants and consultants also derive great pleasure in providing the hospital, free of charge, with the benefits of their expertise, experience and networks. Who knows what extra costs will be incurred by hospitals that are not able to call upon these free services any longer? People often ask me why I got involved with the board. I served as a consultant for them, and then they probably figured, "We can get this guy for free if we put him on the board." It works.

There's a great similarity in all our roles. We are all working hard to provide the people of our communities with the health care they deserve. I do not receive a salary or even expenses. The only remuneration I receive is the feeling I get that I'm making a difference. Don't pass this bill the way it is written and deprive me of that. Thank you very much.

The Chair: Thank you, gentlemen. You started at 11:02 and it's 11:12, so we've got about six minutes per party, starting with the Liberal Party this time.

Ms Smith: Thank you both for your presentation today. We really appreciate it. I do appreciate the time you put in as a volunteer on a board. My mom sat on our hospital board for a number of years when I was a kid, and I remember the time and commitment it took to better the services we're provided with as a community. So we really appreciate and acknowledge that.

I assume, Mr Schonberg, because you've been involved with some of the OHA discussions, you're aware of the minister's statement that was made on Monday. I don't know if you've seen it as well, but I will provide you with a copy if you haven't.

Mr Polowin: Thank you.

Ms Smith: In it, the minister makes very clear that the accountability agreements we are looking to institute through this legislation will be between the boards and the ministry, and not with the CEOs. The boards would then be expected to enter into performance agreements with their CEOs which reflect the accountability agreement. I think that goes some way to calming the fears that have been raised about lack of recognition of boards' existence or undermining their governance authority. Certainly we don't want to do that. We recognize that boards are doing a huge service and governing their institutions well, and we want to make sure that continues.

I want to just make sure you knew that those amendments are coming forward, as I'm sure you know, Mr Schonberg, because we've been in discussions on these with the OHA for some time, as well as with other stakeholder groups. What we've done in this instance is bring forward this legislation after first reading, recognizing there is work to be done and asking for your submissions. That's why we're here, and that's why we appreciate that you're here. Although the members opposite may feel this is not an important exercise, we on this side certainly believe it's an important exercise and we want to get your input. So we appreciate your taking the time out of your busy schedule.

I was interested in your assumption or speculation that the accountability agreements we're looking at in this legislation are similar in type to BC. Where does that assumption come from?

Mr Schonberg: It comes from the joint committee I sit on between Ministry of Health officials and ourselves. In fact, I think it's a wise thing. We're looking at the agreement from BC; we're looking at agreements in Australia. I'd just comment that the common premise in all of them is that the agreements are made between the political head—the minister, if you will—and the board. But certainly BC is our prime example. It has existed for a year or two, so it makes a lot of sense to use that as a guidepost.

Ms Smith: In your discussions, obviously you're using it as a guidepost and not the absolute model. You're using it as a starting point from which to build a type of agreement that would suit the Ontario model.

Mr Schonberg: Yes, absolutely.

Ms Smith: OK. That's great. I know one of my colleagues had a point to raise as well, so perhaps I'll pass it on to Mr Levac.

Mr Dave Levac (Brant): Thank you very much for making your presentation. I also want to make mention of the fact that in your very thorough presentation you have identified the good parts of the bill. We're not going to throw out the baby with the bathwater and you're offering us recommendations. As I had the opportunity to say to the presenters before you this morning from the Ottawa Academy of Medicine, the OMA and the rest of the people on our deputation list, which goes right to 4 o'clock, thank you so much for bringing your concerns forward. They will be listened to.

After a first reading bill, I'm assuming the groups talked about the potential for making amendments and that there were amendments offered on several occasions. I understand you're working with officials to speak specifically to the changes you're proposing and would offer those amendments to us in some form, either in this deputation or in writing, so we could look at how we can improve and make the bill even stronger. Is that a fair assumption?

Mr Schonberg: Yes.

Mr Levac: In a nutshell, we are still going to Windsor, Niagara Falls and Queen's Park to receive more deputations from more people who have issues.

I can say to you that negotiated accountability agreements are a reasonable thing to request, and I thank you for those observations. Also, the dual accountability you spoke of—I think this government has indicated, either through the throne speech or through other actions up to that point, that they believe there is a dual accountability that will be built into this bill or other bills that will be coming forward.

Other deputations made the comment, in general, that they're looking at wait times. Some of the members on both sides have made comments about wait times for psychiatric help, wait times for surgery in the hospitals, wait times, period, and all the other changes. Is it your belief that this bill is the only thing that can encompass those particular concerns that are raised? Would you believe that legislation to follow could take care of some of those issues as well or do you think it needs to be put into Bill 8?

Mr Schonberg: I think Bill 8, as has been said before, is focused on accountability, and really focused to a large extent on ensuring accountability from hospitals in particular and health care providers, back to the government, yet the preamble and even the name of it really speak to ensuring the tenets of medicare. So I guess the supposition to you would be that if I look at the preamble, this bill is probably where accessibility should be covered, as well as accountability as the sixth principle. That would make sense.

Mr Polowin: If I could just make a comment about accountability, as a volunteer board chair, I think it's already there. I know about the discussions that take place in our board. I know of the work my board members do in terms of realizing how important they are to the system, and the thin line that I as a board chair have to walk. On one side, I'm responsible to the community, to the people of our community, to you; on the other side, I'm an advocate for the hospital itself. And all the while I'm aware of how important deficits are, of not being in a deficit position, of how money is spent, how the hospital operates. I think that for anybody to expend the kind of energy we do, we'd have to be aware of accountability; otherwise, why would we do it?

Mr Baird: Thank you for your presentation. The parliamentary assistant said that we on this side of the committee don't think it's important. That's ridiculous. We obviously think this bill is important.

What would happen if the two of you went to the annual meeting of your membership, the people who elect the board, and said, "We've got a big report about the future of the hospital. By the way, we're going to make major changes to it. We think it's terrible. We want to apologize for this report"? Or would the appropriate thing be to simply withdraw the report and get it right the first time? That's our argument, and I want to correct that.

I want to talk about accountability. There's nothing in this bill about the accountability that either the provincial government as an institution or the Ministry of Health or the Minister of Health has to you, as CEO. What do you think of that?

Mr Schonberg: To me, that's why the operative word is "negotiated." That's been mentioned many times. That has to be part of it. What we're talking about is that if we have an obligation to provide a certain quality and a certain amount of service, that can only be done if we know what resources we have; ie, what funding we get from the ministry, that it's guaranteed and that it's early enough so we can plan for it as well. By that nature, it has to be a two-way street. Government has to provide us in advance with what resources it can afford to provide to us, and we, based on standards, can then say, "Yes, based on field standards across this country or internationally, this is what we can give you back."

Mr Baird: But if we're talking about waiting times—everyone wants an accountable system; no one can argue with that. The growth in the population of the folks you serve, the acuity level of care required by the elderly out your back door—you can't control how many people come into your emergency ward; you can't control how many physicians come in to do deliveries in the obstetrics ward.

I appreciate negotiating the accountability agreement; it's fantastic. But nothing I heard in the minister's statement on Monday and nothing I've heard today—they'll negotiate your accountability to them, but I haven't seen anything to say what their accountability will be to you. Getting the budget ahead of time would be fantastic and great, but you and I know there are so many factors totally outside your control, whether it's funding levels for home care, rehabilitation services, supports for other professionals that fall outside of your mandate. They have a huge impact, whether it's an issue like SARS or a flu epidemic. I guess I'm just troubled by that.

1120

Mr Schonberg: Certainly the only way this will work, John, is if it is negotiated. Also, we're developing principles right now. It also has to be flexible, for exactly the reasons that you said. So that's why it cannot be unidirectional if something like SARS happens or there is a group of physicians from a certain speciality that leaves. The whole premise of this accountability has to be that it is on an ongoing, negotiated basis, that it's flexible, that it's revisited. It's a living contract. It has to be. Therefore, that's why it makes no sense whatsoever for it to be unidirectional.

Mr Baird: With respect to the accountability of medical staff, it was reported earlier that there will be amendments specifically saying physicians aren't covered. But if a physician is serving in management, whether it's your chief of staff, whether it's the head of a department—by law you have to have physicians on your board. How many physicians would you have in a quasi-managerial capacity at the hospital?

Mr Schonberg: About 15 in total.

Mr Baird: And you're a community hospital.

Mr Schonberg: Yes.

Mr Baird: Have you ever talked to them? Have they said anything about their concerns with respect to this imposition of accountability?

Mr Schonberg: Certainly they have. To be very fair, I think the clarification has been made that the accountability would be between, minimally, I guess, the hospital, the CEO and the board. So yes, they're concerned. The concern there is mostly to do with the provision that's in the existing bill about not being able to extra bill for specific physician positions that could be on salary or negotiated outside of that arrangement. But their overall concern is that any agreement that we have collectively has to be flexible and negotiated.

Mr Baird: And just finally to you, Mr Polowin: Do you have an accountability mechanism for your CEO?

Mr Polowin: Very much so.

Mr Baird: Is that just something you got last week or last month?

Mr Polowin: No, it's been in operation—I don't know—three, four years.

Mr Schonberg: Four years.

Mr Baird: So it's there.

Mr Polowin: And it's solid, too.

Ms Martel: Thank you to both of you for coming today. I appreciate it. I wanted to look to the slides. If I can deal with page 4 of the document that you gave us, it would be slide number 14, entitled "Ensuring Accessibility." It says:

"What Bill 8 fails to do

"Ironically, Bill 8 abandons a key accessibility criteria under the Canada Health Act, which the bill purports to enshrine.

"Bill 8 excludes any legislative requirements to fund the system adequately, as set out in the accessibility provisions of section 12(d) of the Canada Health Act, which in the case of hospitals stipulates that "...the health insurance plan of a province must provide for the payment of amounts to hospitals ... in respect of the cost of insured health services."

That's pretty strong language in terms of what the bill fails to do, particularly with respect to accessibility, which of course is one of the tenets of the Canada Health Act.

Certainly the government talks about accessibility in their preamble and yet, as you've just pointed out, there's a big gap between what's said in the preamble and what actually appears in the provisions of the bill. What do you think about a bill that's got a preamble that of course everyone would support—who doesn't support medicare in this country? Of course, I would expect everyone would support page 1; it's the rest of the document that doesn't support what's on page 1 that concerns me. I'm assuming from your pointing out accessibility, you've got a similar concern.

Mr Schonberg: Yes.

Ms Martel: In terms of the bill itself, then, what should the government do, draft a new bill using page 1 and get rid of the rest of it? It's very clear that part II is essentially another bill, the Health Care Accessibility Act, which was already in place; it has some revisions. Part III is all of the sections that most people have come forward and said are the draconian new measures the

minister has which should go right out the window. That essentially leaves part I, referencing a Health Quality Council, which will have some role to survey and provide reports but not make any recommendations to the minister about doing anything. What should we do? Just keep page 1 and start again in order to actually put something in place that's going to be meaningful to people when we talk about medicare? What's your suggestion?

Mr Schonberg: I have to say I'm not a politician—thankfully, I guess—but in answer to your question, certainly the preamble speaks again to the tenets. We're supportive of a negotiated accountability being part of it, but you're absolutely correct. It should, in our opinion, address accessibility; it should address the other parts of the bill.

The other comment I would mention that we have brought forward is that—Shelley, if you don't mind, I will address this. You asked this of the previous speaker: Why do you think it has occurred? Very candidly, I think there are circumstances in our field, as in every field—we see that federally currently, right now, where you can have a runaway hospital, you can have a runaway governing board or CEO in that way as well. It can happen in any private or non-private business.

The fact is that there is existing legislation through the Public Hospitals Act, which has been used right here in Ottawa, to put in place a supervisor with the powers to remove a board and/or CEO if that's deemed appropriate in the public interest. And that's the key issue: It's in the public interest.

That's not something we're saying should not be there. It's already covered. There's a mechanism to do that in another bill, so we honestly have to scratch our heads and say, "Why is it that draconian in this specific bill?" If you want to get at non-performers, there's a way of doing that. There's a way of doing it properly with negotiated agreements where you would recognize that the vast majority are good performers and deal with the non-performance through many other mechanisms. We have recommended, for example, that you can have third-party arbitration, which can be through operational reviews, as our own hospital went through two or three years ago with the previous government. It was relatively fair, I would say.

Those are mechanisms that, I would submit to you, would be fair to do and are appropriate to bring into line. Or if there's a question about the management of a hospital, that's how you can do it most appropriately. It should not be, in our opinion, resting with a select few, the minister—and quite honestly, I don't believe it would be the minister; it would really be with the senior bureaucrats, and that to me is a very dangerous precedent to set.

Ms Martel: I appreciate that you raise the Public Hospitals Act, because we had that suggestion raised with us by the last set of presenters in Sudbury. By the way, our own regional hospital in Sudbury also had an operational review, a capital review and a supervisor as well, so the mechanisms of the Public Hospitals Act were utilized in our hospital as well.

What's interesting is that not only does the government have new mechanisms which take us far beyond the mechanisms in the Public Hospitals Act, they take us about where we were with the hospital restructuring commission, if I might, and some of their powers. But at any rate—

Mr Baird: Don't look at me. Look at him.

Ms Martel: But the words "public interest" don't appear anywhere in this bill. So not only have we moved far beyond, with powers that I think are quite draconian and reflect some of what we saw before, but now don't even reference public interest. How does that make you feel, you as a CEO who's trying to coordinate some of this, and Jeff, as a chair, to see the government move so far? We heard the same thing yesterday, that you can't see any evidence of broad-scale incompetence, money mismanagement across—how many hospitals and chairs do we have? Some 172 or 173? I'm not sure what the number is.

Mr Polowin: As a volunteer, I remember the interviews we did for people who were interested in becoming members of our board when we had some vacancies. Every one of them talked about what had happened at the Ottawa Hospital. So anybody who enters into this type of arrangement as a volunteer is well aware of how accountable you have to be already.

The Chair: Thank you, gentlemen. We appreciate your input this morning.

1130

OTTAWA HOSPITAL

The Chair: The next group, as I understand, is doing a PowerPoint presentation. The screen appears to be almost at our backs. If anybody would like to perhaps change seats, as the presentation is quite necessary, is it?

Ms Peggy Taillon: You actually have handouts of the presentation as well.

The Chair: OK. Ms Taillon and Mr Hession, welcome. You've got 30 minutes.

Mr Raymond Hession: Yes, Mr Chairman, my name is Ray Hession. I'm chair of the board of governors of the Ottawa Hospital. The previous presenters are a great segue for me, I must say. With your indulgence, Mr Chairman, I'm probably going to modify the presentation, although the materials are there for your consumption. But I would, like you, prefer to have more of a dialogue in the course of our interaction. An awful lot of what I would be saying in the presentation you've just heard from the Capital Health Alliance, in which our hospital is a major player. So again, with your indulgence, it's not to de-emphasize the issues that were made; quite the contrary. But with respect to the formal presentation you've just heard from Queensway-Carleton, I would simply say "ditto" vis-à-vis the core issues that were raised by them.

I think it's always helpful to introduce the hospital to you so you have an appreciation of where it fits and what are its essential characteristics, so I am going to cover

that part of the presentation and then I'll become a little more extemporaneous in my comments. Then we can get into questions, which is the more important, the meatier, part of the exchange.

I'm joined, as you can see, by my colleague, who is the director of executive services for the hospital. Peggy Taillon is her name. She is one of the very remarkable senior people in the hospital who tries to connect on a day-to-day basis between myself and the CEO as we get on with our respective roles—a truly exceptional person. Peggy is going to help me with the presentation.

Let's get into it, shall we? The first slide, which you have in front of you, is simply asking the question, what is the Ottawa Hospital? Without attaching too much significance to the past, this hospital has undergone probably more degrees of change, I would say, than any other hospital in the province in the last five, now almost six, years. It's the result of the hospital restructuring. The three significant hospitals in the area, not to cast any aspersions on the Grace, which is no longer with us, have been amalgamated, a five-year journey that, upon assuming my office and that of my colleagues the board of governors, essentially was coming to its natural end. But getting there, five years on, was tortuous, without doubt; tortuous financially, tortuous in cultural terms, tortuous in terms of efficiencies and so on, most of which are behind us now. Indeed, we're into a new era where we're starting to see the efficiency gains and other qualitative improvements arising out of the amalgamation.

But do not underestimate the degree of impact of changes of this magnitude. I don't want to liken that to the sorts of impacts that this bill may visit on hospitals, but the sensitivity around my hospital to changes of this nature is very high because we've come through such a tumultuous period. That period, among other things, can be characterized by a particularly strong focus on the very issues that you're now concerned with in this bill.

Accountability has been worn on everybody's sleeves in the Ottawa Hospital for a very long time. I sit here as the chair, surrounded by a management team that I find exemplary—I'm quite prepared to speak further to that—and a board of governors that is equally so. Highly qualified people. I ask myself every day that I encounter either of those two parties accountability-related questions. They're almost all performance-centric—how are we doing on this or that?—that we know to be part of our well-thought-through plans. Accountability, as I say, is on everybody's minds in my hospital.

Let's just bring up the next slide, if you would.

Ms Taillon: It's not working.

Mr Hession: Aha. The tyranny of technology.

Let me tell you, we're a big hospital. In fact, arguably we're the largest in the country. Some hospitals in Toronto might argue that point, but in terms of bed count, physicians, the nursing staff, in terms of the volume of activity that passes through our doors, if we're not number one, we're certainly number two.

Another way of looking at it, in the context of the catchment area we serve, mainly eastern Ontario—not

exactly defined as such but close to that—is that we represent a little over a million people who look to us as the only critical care hospital in the region. Those of you who represent ridings that are in the metropolitan areas of, say, Toronto or the Golden Horseshoe really have to understand this. We're the only game in town, whereas if there's a critical care condition in the metropolitan Toronto area, for example, there are at least six, probably seven, critical care hospitals to which a person can be deployed if indeed there is a problem in an emergency department in any one of the other hospitals. That's not true here. We're it. So the management processes we have to put in place and the extent to which we have to respond are unique.

I dare say there are other such situations. I understand the member from Sudbury might see somewhat the same situation, but it's a very important distinction. With that in mind, let me indicate also that in the context of our accountability mindset, our hospital has excised from our operations \$38 million of cost in the last two years. We do that partly as a direct consequence of the supervisor and the operation review that was done, but mainly, interestingly, we do it as a consequence of the attitude of our people.

They were told that we have a sustainability issue in the Ottawa Hospital, which is not unique—it's everywhere in the province—and we have to pull in our horns on any discretionary spending that isn't relevant to our principal mission. So the management, led by an exemplary CEO in the person of Dr Jack Kitts, has by consensus, including the doctors and the nurses, come to a meeting of the minds to say that yes, we can do better and reduce our costs by, as I've said, cumulatively \$38 million.

Some of you know that during the last election, out of the most genuine frustration you can imagine, I, on behalf of my board, sent out into the public domain to many of the candidates of all parties a document that said that the financing of our hospitals in this province is broken. It isn't this year, it is a systemic problem and it's one that's got to get fixed regardless of which party would end up governing. I simply wanted to achieve a debate that was meaningful both to you as politicians and to us as honest volunteers and others trying to make this thing work.

So when I attach that act and its significance to your issue today, which is the accountability of the hospitals in this province, it speaks volumes about the misalignment between your role as government and your role as legislators and our role as people who have to make it work within the envelope of resources that we're given. This is critical. We are faced with a serious problem of misalignment, and I would put that problem ahead of the accountability issue with which you're now dealing. I don't want to leave the impression that we're not in agreement on the fundamental principle of accountability in the public sector. We're absolutely in agreement.

Some of you know me well. I've spent 40 years of my life in the public and private sectors and I know a lot

about the subject of accountability, both as a public and a private sector board member, a chair of a board responsible for two audit and governance committees and public sector companies traded on the TSE. I understand this stuff.

I sat, as I thought I heard one of the previous speakers say, on the joint planning and policy committee of the OHA, and I have to tell you in all candour that listening to the discussion, including the officials of the ministry, it was amateur hour in terms of the ability of people to articulate what they meant by accountability as expressed in a form of performance agreement, whether between a board or between the government and the CEO. Regardless of that, you've got to get the performance metrics right, and there has to be a structure and logic in that performance agreement that aligns the parties in a way that we're all singing off the same page—I think I just mixed my metaphors there. Singing off the same song sheet is what I really meant.

On that, let me just spend a minute talking about what we would do, given our druthers, in terms of this bill. I'm entirely motivated by a productive outcome. I'm not interested in being critical of the bill. Much has been said about that. I have the impression that members on all sides appreciate that it's significantly flawed. That's fine.

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I believe that we need a robust accountability framework. I believe that such frameworks exist today in a great number, if not most, if not all, of the hospitals in our province. We must remind ourselves that the hospitals in Ontario, when you look at CIHI data and talk to persons in Health Canada who have a more national purview, are amongst the best managed and most efficient in the country. Don't forget that. When we talk about accountability, let's contemplate learning from all of what's been done in those very hospitals, drawing the distinction, as is necessary, between teaching hospitals such as my own or the community hospitals that are the majority. They are different in their characteristics, they are different in their performance measures, and so on.

Drawing those obvious distinctions, go into any number of them—you're welcome to come to ours—and have a hard look at exactly how we achieve accountability. I'll spend a minute on that, if I may, Mr Chair. Find out what are the characteristics of the highest-performing hospitals in this province. That's a clue to what should be the accountability framework. It's not a matter of abstract academics. It's a matter of: that's a high-performing hospital; that's their accountability framework; that's a good model that we should consider.

I don't see any sign of that. I'm shocked. I sat in a meeting—I'm going to share this with you; I don't want to offend anybody. I was shocked to hear an official from the ministry, a well-meaning person, talk about the accountability arrangements that are being inculcated into the New York Stock Exchange. I said, "What in hell has that got to do with the hospitals in Ontario?" Interesting question, but it happens to be on the front page of the paper and on everybody's mind. But it's a sign of the

misguided nature of what's actually going on. The real evidence of real capability to achieve the accountability that you quite legitimately seek is in the high-performing hospitals today, right in our province, and we are national leaders in that respect.

In my hospital, with our very fine president, we have delegated authorities to him as a board. The authorities of boards in public hospitals are quite unique and robust, let us not forget. We've delegated these authorities on the condition that he produce for us the evidence of the outcomes that we seek, whether in the area of quality, human resources, business processes, whatever we think is important. He's now busy, for this current round, building those plans. Those plans will come to us. There will be clear performance outcomes contained in each one. In HR, we're looking for productivity gain. In the quality area there's a whole gaggle of things we'd like to see improved, including access. Obviously there are issues around safety and so on and so forth. But it's a very robust document, and by the way, it will be a public document. It will be out on our Web site so the whole community that we serve can see exactly where we're going with their money, which is the money that you have to husband—they being the taxpayers—and that we have to make sure we execute effectively. They have to know what we're doing. We may not always agree; I hope we do.

The outcome is the evidence of alignment between what the current government wants in its health care system, what our hospital is actually doing, and the extent to which that's relevant to what our community wants. We, the board of governors of this hospital, are doing our very best to connect with those two quite relevant constituencies.

If that's a sign of a high-performing hospital, you're all welcome—you, your officials—to come in, have a hard look, figure out what the attributes of a high-performing hospital are and import those attributes into your legislation as attributes—not a whole bunch of dictates which may be irrelevant to some hospitals; the attributes. Then undertake as a government to say, "From year to year, we will take those attributes and specify what it is we seek from you." I tell you, it would be an all-time first if government did that. We'd take that, we'd inculcate that into our plans and we'd generate executable, real, live stuff that would achieve those outcomes. Accountability would be aligned.

We would debate with you if we can in fact afford what it is you're asking us to do. That's a fair debate. Frankly, I've polled our CEO and he's now ruminating on this. I said I don't want to get into this business of speculating with the current government as to what might be the up tick in our budget next year. That's a mug's game. For two years I've done that now and it's never turned out to be right. In fact, I get sandbagged and I get blindsided left, right and centre. I don't want to do that. So we'll say from now on we're going to budget on the basis of exactly what we know, which is our current operating budget. We're not going to make any assump-

tions about growth. We're going to explain to the government, as an accountable entity, what it means if there is no up tick, what programs will have to be reduced, changed or whatever. Then the accountability connection occurs. You make the funding decision. That will affect my ability to deliver services. It's up to you. If you don't want to fund it, we'll cut the services and we will agree on what those cuts are.

I'd like to conclude with this thought. There was a question that was asked by one member about how many doctors are performing management functions. In our hospital it's about 70. We're a big hospital. We have about 41 programs, I think, something like that. Those people have been sitting in a room, off and on for the last three months, and they will continue to do that through this month, determining the clinical priorities of the Ottawa Hospital. That means there is a hierarchy, an order of precedence, as in acute care hospitals, as to what programs are more significant or important than others. Down at the bottom of that list the lower-priority programs are found. So if there's a funding problem we will know, and our doctors will be in agreement, to focus on those low-priority programs if cuts have to happen. Again, we're going to make this entirely visible to you politicians, to our community. It will be a ready accountability framework if, as in when, we run into a resource constraint. Thank you.

The Chair: Thank you, Mr Hession. You've used up about 18 minutes, which leaves us with 12, starting with the PCs for four minutes.

Mr Baird: I don't have any questions. I just want to thank you for your presentation. I think there is a lot of wisdom in the underlying thought on your summing-up page, on the back page, that it would be a very bad move if we went to a centralized system where boards merely become advisory boards and everything is tried to be run from the Ministry of Health. I think there is always the push for that to come—if you centralize something, it will be better. I think there is probably no greater example of accountability that the ministry can exercise than it has with appointing the supervisor and removing the board. You look at the hospital a few short years later and it's in demonstrably better shape, with a lot of great people and staff morale. Thank you for your presentation.

Mr Hession: It was a pleasure. I would just remind you of the New York Stock Exchange point. You talk about centralizing and trying to figure out the right fit for hospital A, B or C, as the case may be. I was shocked by that, to be perfectly candid. We can't have amateurs at the other end of this transaction. We're serious people and we expect to be treated seriously.

Ms Martel: Thank you, Mr Hession. Mr Baird reminded me of when we last saw each other. It didn't dawn on me until you sat down and he pointed out that you came in to fix the mess with Accenture.

Mr Hession: Yes. I enjoyed our interactions at that time.

Ms Martel: You should know that we talked about Andersen/Accenture at public accounts last week, and I

asked the deputy at that time, who right now is Mr Costante, if he could assure us that Andersen/Accenture will not be allowed to bid on the new computer system at the FRO. He could not provide me with that guarantee, so I hope you're not back in that capacity, cleaning that up.

Mr Hession: You and me both.

Ms Martel: But let me move to the presentation at hand. I'm looking at the second-to-last point on the summary sheet that you provided in the package. Point number one says, "It appears that the government intends to remove accountability from the board and re-establishing them as 'advisory bodies' to government or worse, making hospital boards redundant." We have certainly heard that concern and people's concern that unless there are significant changes, people will not sit on boards.

I find your second point quite interesting: "Given the government's decision in recent years to divest ownership and management of provincial psychiatric hospitals in the province, it is unclear as to why the government would want to move in this direction." I just wanted to know if you could more fully articulate your concern with that.

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Mr Hession: We have the great benefit of having on my right-hand side a true authority on the subject, so I'm going to ask Peggy to comment on that.

Ms Taillon: As part of the Health Services Restructuring Commission work when they went around and reviewed hospitals in the province, they did look at the provincial psychiatric system as well and made some recommendations about divesting provincial psychiatric hospitals, which were at that time effectively managed by government, by the Ministry of Health. They divested these programs to the public hospital sector. This was only three to four short years ago that this process took place. You can imagine the wide-sweeping human resource/union implications for the mass move of psychiatric hospital employees from OPSEU to whatever union they were moving into in the public hospital sector. There were huge costs incurred by government and by taxpayers, so the dust is really just settling on this work.

If you look at the provisions in Bill 8, we're almost moving back in that direction. So within three years we're almost moving full circle. We wanted to point that out as an area of concern for us. We really supported the direction the government had taken through the provincial psychiatric hospital divestment, so that was that point.

Ms Martel: The point that follows that is, "We do not believe it is the government's intention to manage every hospital" directly through the bureaucracy "and emphasize that the provisions of the bill that undermine the Public Hospitals Act and the role of voluntary boards should be significantly amended."

There certainly has been a suggestion that the government already has at its disposal any tools it would need to deal with concerns about fiscal mismanagement at an

individual hospital and it can do that through the Public Hospitals Act. Do you have a view one way or the other in terms of, should we essentially get rid of the section that we see here and allow the ministry to intervene when it feels it has to via the Public Hospitals Act, which has a clear statement of doing that in the public interest, and that is articulated in the bill? Or do you see some value in trying to reorganize or amend or patch up, or whatever the government chooses to do, in part III of this bill and still retain the accountability sections? Maybe the provision about "in the public interest" has to be added. I'm just not clear what is the best mechanism for the government to follow at this point.

Mr Hession: It's a hard question because it can get us into a discussion of the degree of partisan views on this and I don't want to do that. But I do have a suggestion for you, as legislators, to consider. The province, at least as it is represented by the hospitals and as I see the evidence, more and more getting into my current role of uncertainty—the uncertainty is awful around both the legislative environment and certainly in the hospitals. Uncertainty is, for sure, the first step toward chaos. Be careful. Change is a nice thing, but be careful.

I would ask you to consider this, and I'm getting a little out on a limb here because it's not my business. I would say the greatest thing you could do as a Parliament, as a Legislature, is unanimously pass a resolution. Don't get into legislation quite yet; pass a resolution. As someone said, "We all agree with the preamble." It's good and Ontarians want to hear from their political leaders that "This is unanimously agreed by we, the Legislature of Ontario, at this time."

Then, take a look at the instruments that are available to you, as government in particular. We've been on the receiving end of those instruments in a major way in my hospital. The number one issue that I would say arose in my own mind is the degree of containment on the outcomes the government of the day seeks as a result of the appointment of a supervisor. The one I saw was pretty open-ended and it went on for 14 months. Why, I'll never know, but it did. It could have been done far faster with very clear outcomes expected by the government. It makes the provision in the act perfectly OK, but in its administration I would ask you to consider things of that kind, very practical things.

My hospital was in the financial dumpster. We spent a ton of money on a supervisor whose work could have been done in half the time that it actually took, for example. It didn't look right to me, for obvious reasons. I don't know what your experience was in Sudbury.

The Chair: Thank you. Could you summarize?

Mr Hession: I just did.

The Chair: Thank you.

Mr Hession: Sorry, Mr Chair.

The Chair: You're right. Some things can take shorter.

Mr Hession: Yes, they can. Sorry about that.

The Chair: No, I was enjoying the answer. It was just going over time.

Ms Smith: Thank you, Mr Hession. We really appreciate your presentation today. It was far-ranging. I just wanted to touch on a couple of things, and some of my colleagues have some comments as well. I will try to do the best I can in less than four minutes.

You talked a bit about the funding issues, and certainly we hear that loud and clear. We hear that from most of your colleagues across the province. We are, as you know, working with various stakeholder groups on multi-year funding agreements and arrangements, and I understand that's ongoing.

I appreciated your suggestion about best practices, looking at those facilities that are performing at the highest level and using those as examples or models for building our accountability agreement. I'm presently undergoing a review of long-term care facilities across the province. Certainly that's been my modus operandi, to go in and look at the ones that are run well and see why, and then use that as a tool for improving the others and making sure that the standards are set across the province.

Before I pass it on to one of my colleagues, I want to ensure that you did receive or have received a copy of the minister's statements on Monday, where he outlined some of the possible amendments that we'll be bringing forward in the future, talking about the fact that the boards will be in place, will continue to be in place—the agreements will be between the boards and the ministry—and then looking at performance agreements between the board and the CEO. Just in your summing up section, I just wanted to address some of that.

Certainly I, having one of the last three psychiatric hospitals in the province that's still run by the province in my riding, am totally aware of all the issues surrounding that divestiture. Certainly that is not, I think, the model that we're working toward. We respect the boards in place; we respect the work that they do. The accountability that we're looking for is simply to add transparency and a sense of comfort for the people of Ontario that their money is being well spent in the health care field.

I'm going to pass it on now to my colleague Mr Brownell, who has a couple of comments.

Mr Jim Brownell (Stormont-Dundas-Charlottenburgh): Just a couple of comments. As an MPP from eastern Ontario, it's a delight to have had the opportunity—we almost got bogged down here—to have you speak to us. It was refreshing; great ideas. I had picked up on the best practices ideas, and Monique, my colleague, made comment on that. I think it's very important that we look at those. I'm very familiar with your sites, being from eastern Ontario and with that relationship with Cornwall. It's so important that we understand what's best in our hospitals and whether we can build on that.

I do want to say, there is language in the bill that has to be looked at. The tone, the language, some concepts—we really have to look at that. We have to look at what the presenters are doing here. You are presenting ideas to us that we will be able to take in the clause-by-clause and

work with in building something that's going to be a model. I know that I appreciate, as my colleagues do, what you've presented here.

Mr Hession: Thank you very much. Mr Chair, there is one point that arises out of Ms Smith's comments: multi-year funding. Not to sound abusive, it's nonsense. Why are we talking about it? You can't do it as a Legislature. You approve supply annually. To take away that privilege from a Legislature has never happened, to my knowledge, in a British parliamentary system. I've said this time and again to the OHA. The issue isn't multi-year funding; the issue is stable funding, which is exactly the language that I saw while you were on the hustings, which I thought was great.

The problems are now. We need to fix the way in which we allocate resources now. If there be multiyear funding, I want to say again, it's not the health minister that I'd worry about in that respect, it's the finance minister. What's he going to say? What's the Premier going to say? If you're going to lock me into a future without reference to the Legislature, there's no jurisdiction in the Western industrialized world that has achieved multi-year funding. So why we think we're going to miraculously do it is beyond me.

I just say that in good faith. If you could just fix the way we do it annually, we'd be happy as clams.

The Chair: Thank you very much for that closing, Mr Hession.

Mr Baird: Other than that, you're undecided.

Mr Hession: Other than that, I'm absolutely vacillating, Mr Baird.

The Chair: Thank you very much for joining us today. We did appreciate your presentation.

Mr Hession: It's a pleasure. Thank you for coming to Ottawa. We're delighted.

The Chair: Our pleasure.

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OTTAWA AND DISTRICT LABOUR COUNCIL CITIZENS FOR A PUBLIC HOSPITAL

The Chair: We can move on then to the Ottawa and District Labour Council, represented today, I understand, by two people, Sean McKenny, the executive secretary, and Caitlin Kealey from Citizens for a Public Hospital. Please be seated. Make yourselves comfortable. You have half an hour to make your presentation.

Mr Sean McKenny: I'll go first and then Caitlin will follow with the Citizens for a Public Hospital.

Just before I start, one thing I noticed with some of the presentations earlier this morning and specifically the one just before this, is that it to me says what this whole issue is about. We had an attempt at a PowerPoint presentation, certainly a reference to those who have—we have scrap pieces of paper here. The technology didn't work. Again, to me it's representative of those that have. This whole issue in regard to health care is about the average individual who lives in our province. I really do believe that's

lost on so many, and, I think, lost around some of those around the table, and that's unfortunate. When I hear things like the New York Stock Exchange referred to when we're talking about health care, it certainly causes me very deep concern and, I would suggest to you, a lot of people concern.

In any case, good morning. The Ottawa and District Labour Council comprises 90 different local unions representing approximately 40,000 working men and women in the Ottawa area. Those individuals come from a variety of workplaces, inclusive of our hospitals and other health care areas.

We thank the committee for being here today and listening. We truly hope that this process of hearing from the community as it relates to health care is one that provides the listening on your part—somebody over on this side mentioned that just earlier on—and the realization that those making presentations do so because they have a deep, embedded concern about Canada's health care system, a concern that wants to ensure that our system is strengthened and made better. To be made better is not defined as a mechanism for those whose only interest is to make profit. Clearly, Bill 8, the Commitment to the Future of Medicare Act, introduced by the newly elected Ontario Liberal government back in November 2003, is an attempt at that and certainly an admission that the system needs some fixing. However, from my seat, several areas of the bill fail on that level and instead offer weaknesses.

I find it fascinating how certain issues, certain policies, certain legislation, can garner so much interest from some, yet absolutely no interest from others. Assumptions are made that those elected to office, be it at a local, provincial or federal level, or anybody for that matter, make decisions in the best interests of the people they are purported to be representing. If we were to go outside the hotel right now—John, you and I could go out—and ask those walking by if they knew what Bill 8 was, if they knew what was going on inside here, I would strongly suggest, and perhaps some of you would agree, that very few have any idea what Bill 8 is or what's going on inside this hotel today.

I've been working at the Ottawa and District Labour Council for about 12 years now and, not unlike you, numerous papers dealing with a variety of issues cross my desk. Some I have a better handle on than others; for others I rely on others. Not unlike you, who rely on assistants to provide information to you—the labour council here doesn't have much money, so I don't have assistants, but that information does get to me. At the same time, most are able to combine all of that information to form an opinion.

Despite my involvement in a full-time capacity, I still have difficulty. There's confusion. Certainly with some of the previous speakers, I was confused. I don't think I'm a stupid guy; I may be, but I was still confused. If I'm confused, the average person out there in our community, you can be assured, is confused.

Does it have to be confusing? I guess so, because it's so broad and attempts to be all-encompassing. But if it's

that complex, again, to me—I've read Bill 8 twice—no wonder that those outside the building have absolutely no idea what's going on inside here today. Absolutely no disrespect intended, but I would strongly suggest that some of you here don't have as much of a grasp as you think you might surrounding the government's Commitment to the Future of Medicare Act or the Canada Health Act. We get into a game of politics, and that truly is unfortunate.

I'm going to read from a couple of documents that I have from the Ontario Federation of Labour and the Ontario Health Coalition, two organizations that I know you all are aware of, whose work around health care has been incredibly persistent with respect to promoting a health care system that indeed conforms to the five principles of medicare: public administration, comprehensiveness, universality, portability and accessibility.

Before I do that, I'm just going to go back to the Ontario Health Coalition's paper. Again, I think it's important, and I'll say this: It's confusing to me, so I rely on some of this documentation. I've read it from different sources as well, and not solely the Ontario Health Coalition and the Ontario Federation of Labour. In this paper, and I'm sure that some of you have heard it, it's talking about Bill 8 and the Commitment to the Future of Medicare bottom line.

The Commitment to the Future of Medicare Act should include these items:

—Concrete initiative to rebuild comprehensiveness and stop delisting. Are these items present in the bill, yes or no? It's got "no."

—Concrete initiative to protect and rebuild universality, yes or no? It's got "no."

—Concrete initiative to rebuild accessibility to publicly funded services, yes or no? No.

—Improved public access to information, including financial information, about health care institutions and sectors? No.

—Public control, public governance, democratically elected boards? No.

—Restoration of access to home care, including home nursing, homemaking, personal support? No.

—Concrete initiative to improve access to primary care? No.

—Concrete initiative to improve access to assistive devices, treatment and drugs? No.

—A stop to the creeping privatization and Americanization of health care, as promised in the election campaign, big part of the election campaign? No.

—A democratic health council that reports on how the health care system conforms to the principles of the Canada Health Act? Again, no.

—A democratic health council that reports on extra-billing, user fees and two-tier health care? No.

—Prohibition of block fees charged by physicians? No. However, the bill does move control over block fees to the government. We applaud this part.

—A stop to delisting medically necessary services? No.

—Restoration of access of previously delisted services? No.

—Prohibition of two-tier access for delisted services? No.

—Prohibition of queue-jumping for so-called medically unnecessary services? No.

—Increased public input and democratic control? No.

—Whistle-blower protection for those who complain about poor practices by managers and company owners? No.

—Stop to P3 hospitals? No.

—Stop to private MRI-CT clinics? No.

—Stop to defunding unilateral orders for restructuring, reductions in services? No.

—Full public disclosure of OHIP delistings, physicians' out-of-pocket fee list, other charges? No.

—Input of health care workers and patients? No.

—Prohibition of extra-billing? No. However, the bill does ban opting out of OHIP, which we applaud, but leaves potential for extra-billing to the regulations.

I said at the very onset that I don't have a whole bunch of knowledge and certainly none at the same level as some of those presenters before me. But why not? Why not? These things, to me, an individual who has difficulty getting his head around them because of the complex nature of our health care system, make sense to me. The fact that it's not a part of that bill makes absolutely no sense. For there to be excuses as to why it's not there, I don't get that.

I'll go the Ontario Federation of Labour paper and read some of their—not the whole submission, but parts of it. Again, I'm sure that you've heard a number of these concerns before. We'll start with the preamble.

1210

Let me be very clear: There are a lot of good things with respect to the bill. The bill is a valid attempt; there's no question about that. I go back to the comment that was made on this side of the room earlier on to the last speaker, and that is that you're going to take what you hear and you're going to put all of that together and hopefully work on that bill and make it better—make it better for the community, not make it better for those who are really worried about the New York Stock Exchange.

In any case, the preamble to Bill 8 recognizes that "our system of publicly funded health services reflects fundamental Canadian values and that its preservation is essential for the health of Ontarians now and in the future." It confirms an enduring commitment to the five principles of medicare—public administration, comprehensiveness, universality, portability and accessibility—as currently codified in the Canada Health Act. Unfortunately, there is little in the actual legislation that provides any significant new initiative on these principles. Again I'm thinking, why?

Although the preamble commits the government to support the prohibition of two-tier medicine, extra-billing and user fees, a closer examination of the legislation shows it fails to entirely close such options. While the

preamble recognizes that pharmacare for drug costs and primary health care based on assessed needs are essential to the future of the health care system, there is nothing in the draft legislation which directly addresses either of these concerns.

The Ontario Health Quality Council, outlined in part I, sections 1 to 6 of Bill 8, is supposed to monitor and report to the public on "access to publicly funded health services, health human resources in publicly funded health services, consumer and population health status and health system outcomes, and to support continuous quality improvement." It's our belief that this section is, to say the least, poorly drafted. Given the preamble's commitment to principles of the Canada Health Act, it is disturbing to find that the Ontario Health Quality Council does not include reporting on the extent or otherwise to which the Ontario health care system complies with the principles of public administration, comprehensiveness, universality and portability contained in the Canada Health Act. Further, it is not required to report on issues relating to two-tier medicine, extra-billing and user fees. Each one of these issues is fundamental to the health care system and of primary importance to the public.

The council is to be composed of between nine and 12 members, all of whom are to be appointed by the cabinet. What's with that? Really, in all seriousness, what is with that? We are compelled to ask, where is the democracy in this process? Where is the transparency? For all the public knows, representatives from the private, for-profit sector could be appointed as a major step toward eroding our public, not-for-profit system. It is our strong view that for-profit providers, given their blatant conflict of interest, should be excluded from the council.

We believe it is essential that the people of Ontario exercise democratic control over their health care system through democratically elected boards, reflecting and inclusive of various community constituencies, service users, patient advocates and health care staff. Decision-making should be open and transparent.

Should the council have representative and inclusive criteria and elections for its makeup, there is a further issue that should be dealt with. While the council is required to deliver a report on the health care system on an annual basis to the public and to the minister, it is specifically prohibited from making recommendations as to the future courses of action to be undertaken. Again, I don't get it. A good deal of the value of each council is thereby thwarted by its inability to make recommendations.

We support an elected, inclusive and representative council that is free to make recommendations on the steps to be taken to ensure the future of Ontario's medicare system.

I'll skip forward a few pages, then Caitlin can pick up.

Accountability agreements and compliance directives: The most important, controversial and potentially dangerous sections of Bill 8 are contained in part III, sections 19 to 32. They cover the powers of the Minister of Health to compel persons to enter into accountability agreements or

compliance directives. These provisions have been drafted in such a broad manner as to give the minister unprecedented power to require organizations and individuals to comply with whatever the minister desires, potentially including the overriding of legal collective agreements and other negotiated agreements. This constitutes a fundamental affront to the people's rights in a democratic society—again that play with democracy, or the lack of it.

Under the provisions as currently drafted, the minister can direct any health care provider or any other agency or person to enter into an accountability agreement with the minister and any one or more agencies, persons or entities. Even a trade union, under the broad definition of a health care provider, could qualify to enter into such an accountability agreement.

We are opposed to sweeping powers being given to the minister in such ill-defined accountability agreements. Indeed, throughout the bill the powers granted to the minister are too broad, too open-ended. It is often unclear as to specifically what the directives are about; that is, their content and to whom they will be directed. As a person proceeds through the bill, one increasingly gains the impression that the directives of the minister can be to anyone for virtually any reason.

I'll skip another few pages again and go to the conclusion, and Caitlin can jump in.

One would have hoped—and this makes sense to me, again an individual who doesn't have a broad knowledge of the issue, but I do live here—that this bill would have explicitly prohibited two-tiering for so-called medically unnecessary procedures. Accessibility would have been strengthened and ensured, with special attention to marginalized and equity-seeking communities and those communities that are geographically remote, and there would have been some recognition that for-profit provision is a giant step back from accessibility, as can be clearly seen in an American context, where millions of people—millions of people—have no medical coverage whatsoever and millions more are inadequately covered.

One might also have expected provisions on portability to have been included. Currently, Ontario is not covering services for people from other provinces, yet virtually all Canadians travel to different parts of the country at some point and should enjoy the full coverage of that province.

Given the preamble, one could also reasonably have expected to find provisions on pharmacare and home care.

With regard to public administration, we can only once again raise our concerns about the lack of democratic participation and transparency as opposed to open-ended, top-down, sweeping powers to the minister. This is particularly troubling in the context of the province's debt and the consequent cries for restructuring and efficiencies.

Let's be clear. Moving to sell assets such as TVOntario or the liquor board won't solve the problem of a structural deficit; more revenue will. It's a one-shot

deal, postponing the problem until next year. Privatization—and this is big here in Ottawa, where I'm from, with our Royal Ottawa Hospital—in the form of P3 hospitals or whatever is not reinventing government. It's the path rejected by the voters of Ontario, and all the evidence from other jurisdictions tells us it will lead to worse public services.

We urge the Ontario government, in light of our comments, to reconsider some of the components of the bill.

Ms Caitlin Kealey: I want to thank you all for allowing me time to speak and the labour council for giving me some of their time. This is the first time I've ever done anything like this, so I'm a little nervous. My name's Caitlin Kealey, and I'm speaking on behalf of Citizens for a Public Hospital. It's a community-based group dedicated to ensuring a fully public Royal Ottawa Hospital. We are a newly formed group that has joined in the struggle against the looming threat of private-public partnerships. We feel these P3s threaten the core of the Canada Health Act. If I'm not mistaken, the goal of Bill 8 is to try and protect the values and principles of the act. While Bill 8 incorporates the principles in its preamble, it provides no concrete initiatives either to ensure access to services that have already been cut or to implement the sentiments outlined in the CHA.

Home care and pharmacare are the key components of rebuilding an accessible, comprehensive, universal public health care system. So too are homemaking and support services, access to primary care, access to drugs and devices and a comprehensive OHIP list covering the services that people need. The intent of the Canada Health Act is to ensure that Canadians have access to a comprehensive range of medically necessary health services. Real, concrete steps are needed to fulfill this vision of a truly universal, accessible public health care system. This universality will most likely come under fire if this bill does not explicitly protect our public system from for-profit and private companies.

The threat of the two-tier health care system has grown significantly with the continued privatization of our health system. For-profit health corporations see user fees, service charges and two-tier access as potential new revenue and are therefore approaching these ideas in a more aggressive way than their non-profit and public counterparts. An easy example of this are the private MRI and CT clinics. This trend of for-profit clinics being allowed to deliver hospital services poses serious threats to the sustainability of medicare. Access to diagnostics is limited by the supply of equipment such as scanners and trained personnel like radiologists and technicians.

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While private clinics provide machines for which we, the taxpayer, ultimately pay, they do not increase the number of health professionals. The private clinics find their staff by poaching them out of the public hospital system, leading to staff shortages in public facilities. In addition, they seek new revenue streams, including out-of-pocket payments for so-called medically unnecessary scans, a trick to get around the Canada Health Act. A

person who pays for a medically unnecessary scan therefore is allowed to jump the line, using up scarce resources for no reason and pushing back those with medical needs on long waiting lists.

In addition, the private clinics take the less risky and less costly scans, leaving the heavier-burden scans to the public system, which has been deprived of personnel. They also take the third-party-billing patients and those on WSIB, depriving hospitals of this revenue. These clinics make profits at the expense of the public health system.

With the onset of more and more pressure due to financial considerations and private interests in delisting services, the fact that section 15 only prevents line jumping for insured services limits the scope of the bill. The major threat is not really the occasional queue-jumping abuse, but rather from the ongoing shift from public to private for-profit health care service. We believe this shift must be stopped and then reversed.

In October, Ontario elected a Liberal government on a platform of change. In November, Mr McGuinty went to the ROH to announce a fully public hospital. Unfortunately, this announcement offered very little change from the original deal. I have heard from many Liberal supporters who are very upset about these P3 deals. The newly elected government campaigned against the privatization of our health care system, and they should continue their commitment to the people of Ontario.

Clearly, this is not what the residents of Ottawa or Ontario want to see happen in their communities. The suggestion that for-profit companies can build a hospital and run it in a more efficient manner for less money than the government is false. This has been proven time and again through the British experience with their P3s, which are called private finance initiatives. There is much documentation about the disasters that have followed the British move to privatization. In fact, the global evidence is that the more privatized the health system, the more costly it becomes. Look at the results of the massive privatization in the United States over the last 10 to 15 years to see the impact.

In their endless search for profits, corporations seek new sources of revenue, imposing fees and service charges wherever they can. The motivation and means for increasing two-tier health care systems are increased. The result is that the scope of services offered under the public system is reduced. As was the experience in Britain, beds and staff are cut; patients face a barrage of new fees; two-tiering increases; public accountability and access to information are reduced; democratic control is reduced; advertising, consulting and legal fees go up; fraud goes up; executive remuneration goes up; more and more of the health system is governed by a bottom line of profit margins and rates of return for investors.

Further, the trend toward sectioning off the so-called non-clinical services and privatizing them in facilities must be stopped. It must be made clear that medically necessary services include those services that support patients' daily lives, including food, laundry, mainten-

ance, record-keeping, lab tests, diagnostics and therapies. These services are not second-class to patients; they are essential to infection control, nutrition, diagnosis and recovery. They should be provided on a non-profit basis.

One only needs to look at the whopping increases in the cost of drugs, the area of the health system most dominated by transnational profit-seeking corporations, to see the high cost and threat to public access posed by privatization. Fundamentally, the motivations of profit-seeking corporations fly in the face of the principles of comprehensiveness, accessibility, universality and the single-payer system.

The P3 projects commenced by the Tory government here in Ottawa through the Royal Ottawa Hospital and in Brampton through the William Osler hospital, and the seven more that Mr Smitherman has admitted are still in the planning stages, should be immediately stopped, along with the delisting of services.

It has been estimated that such private models can cost at least 10% more than their public sector equivalents. The evidence that so-called public-private partnership hospitals cost more is overwhelming. Following the same model as the privatization in Britain, our proposed P3 hospitals are already showing cost increases from initial projections. In Ottawa, costs are up from an original cap of \$100 million to \$132 million. In Brampton, capital costs alone have increased from a projected \$300 million to over \$350 million.

Making the operation of a hospital private but keeping the ownership public through a mortgage, as Mr. McGuinty announced, does not change the private for-profit character of a P3 organization. I would argue that the mere characterization of public-private partnerships is contrary to the fundamentals of the Canada Health Act. It is a step away from medicare and toward private hospitals. It is one step closer to the for-profit system where those who can afford care receive topnotch health care while those who are not as fortunate receive just OK health care.

If part of Bill 8 is to confirm the accountability of the health care system, P3s are definitely not the answer. P3s put billions of dollars of public funds into the hands of profit-seeking corporations for whom a veil of commercial secrecy obscures public scrutiny over profit-taking and misuse of public funds.

P3s also provide an imposition of two separate sets of management under the same roof, one whose goal is providing a public service, while the other has a goal of maximizing profit and growth. This is fraught with problems. The higher borrowing costs, consultant fees, inevitable legal fees, outrageous executive salaries and profit-taking drive up health care costs, making competing claims on scarce resources.

The Canada Health Act calls for public administration of the health system, recognizing the inherent threat posed by private insurance corporations. Similarly, private hospital corporations, private long-term-care corporations, private labs and private home care corporations are a serious threat to the future sustainability of the Ontario health system.

The current government ran on a platform of stopping the Americanization of our health system. The pre-election promise was very clear: They opposed creeping privatization and committed to rebuilding medicare. Any legislation purporting to show this government's commitment to the future of medicare must include concrete initiatives to roll back privatization and prohibit future for-profit control of our health care institutions.

P3 hospitals must be banned. The private diagnostic clinics must be returned to non-profit hospitals. The tide of privatization sweeping through our health care system must be stemmed. The future sustainability of medicare and the application of the principles of the Canada Health Act depend on it.

Bill 8, as it stands, does not prove the government's commitment to the principles of the Canada Health Act. In fact, P3s preclude much of the accountability, universality and access to a public health system. Take a clear stand against any more privatization.

Thanks for allowing me this opportunity.

The Chair: Thank you, Ms Kealey and Mr McKenny. Unfortunately, we've got about three minutes left for questions. Unless there's any opposition, I propose that we give that to Ms Martel.

Ms Martel: Thank you both for being here today. I appreciate it very much.

Let me deal with the P3 hospitals. I think my colleague Mr Baird said it best just after Mr McGuinty made his announcement here at the Royal Ottawa Hospital. He said there was essentially no difference between the P3 hospital model that the Conservatives had brought in and the one Mr McGuinty announced, both for the Royal Ottawa Hospital and for the William Osler Health Centre. He is quite right.

Mr Baird: On a point of order, Mr Chair.

The Chair: I don't think you can have a point of order during a question, Mr Baird.

Mr Baird: They had red letterhead; we had blue.

Ms Martel: I appreciate the clarification.

We've gone from a Conservative lease to a Liberal mortgage, and what we still have is the fact that public dollars that should be used to provide health care services to patients will be used for profits for the private consortiums that are involved in this construction.

It is very clear, in two ways, that money is going to go in that direction. First, government can get the lowest interest rates, not the private consortium, so there are going to be increased costs because of the higher cost of borrowing. Secondly, of course the consortium is going to do this for a profit—we wouldn't expect otherwise—and that again is money that will now be incorporated into a mortgage that will cost taxpayers more. Our concern, as New Democrats, has always been that that money should be going into direct patient care, not into the profits. That's why government should be building not only these two hospitals, but also the six other hospital reconstruction renewals that the minister has talked about and, we've had confirmed by other people in meetings with him, that he intends to do.

In that respect, do you see a contradiction between the preamble, which uses great rhetorical language about support for medicare, particularly support for public administration, universality etc, and what is not included in the bill, which clearly is stopping P3 hospitals? That is nowhere in the bill. In fact, given what the Liberals have done, it's very clear that they intend continue down the road set by the Conservatives.

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Mr McKenny: You're right, and we agree 110% with those comments. It's not in there enough. In fact, as you indicated, it's not there. There's nothing preventing the P3 hospitals from moving forward. Our understanding is that we're going to see a number of other P3 hospitals built across the province, and that really is a shame. So yes, most assuredly, there should be a lot more in the bill, inclusive of the preamble, preventing P3 hospitals from being built.

Again, don't misunderstand the words; those who hear the message from us saying not to move forward with the P3 hospitals, it does not mean in any way that we don't need new hospitals and we don't need the current hospitals that we have renovated, as here in Ottawa with the Royal Ottawa Hospital. The Tories were really good at that, and John was really good at that when he was in office in trying to make it sound that way—again, those who were in opposition. The reason they were in opposition was that they didn't want to see a hospital built, and nothing can be further from the truth.

Just on that note, we've had a couple of occasions to come in. I'll just be a moment.

The Chair: It'll have to be—

Mr McKenny: Just if I could, and it's in reference to this.

The Chair: It will be a 20-second moment.

Mr McKenny: OK. A number of years ago, when John first came to office, he came into the labour council. He wanted to address those of us from the labour council. He spoke to us as a Tory. At one point during the meeting—there was a number of people there, a number of union leaders from this community—he said, "I'll have you know that my father was a member of the union," and the then president at the time, Mohamad Alsadi, fired back, "I guess your father didn't do a very good job raising you."

Again, the same thing holds true, whether it's a Tory P3 or—

Mr Baird: He said it with the same class as he did.

The Chair: Thank you very much for attending. We did appreciate your input. We'll move on to the next delegation.

Ms Smith: On a point of order, Mr Chair: I'd just like to note that I have fulfilled my undertaking to Mr Klees, who unfortunately is not here with us at this moment, but I would like to deliver to him a copy of the letter that I faxed to the minister this morning, attaching his motion.

The Chair: Wonderful. Thank you very much.

**ONTARIO PUBLIC SERVICE
EMPLOYEES UNION, LOCAL 479**

The Chair: We're now going to move on to—
Interjections.

The Chair: Can I have some order?

We're going to move on to a presentation now by the Ontario Public Service Employees Union, local 479, from the Royal Ottawa Hospital. Marlene Rivier is president. Same rules as everybody else: You've got 30 minutes. The floor is yours, and I've got 12:34.

Actually, before you start, they've extended the check-out to quarter after 1, but that's a firm checkout time. You may find somebody else in your room if you're not checked out by then. So we'll make that 12:35 now. Ms Rivier, the floor is yours.

Ms Marlene Rivier: My name is Marlene Rivier. I am a front-line health care worker, and I am also president of OPSEU, local 479, which represents nearly 200 health professionals at the Royal Ottawa Hospital. We are among the 25,000 health care workers represented by OPSEU in this province. The facility in which we work is on track to become the site of the first P3 hospital in Ontario.

We are grateful for the opportunity to participate in this public consultation and applaud this effort to restore transparency and public confidence in the process of setting policy and direction within the health care system.

We have serious concerns with this bill as it is currently drafted and intend to offer our views on its major sections, concentrating our remarks on privatization in particular, the ROH P3 redevelopment and related issues of recruitment and retention within the health care professions.

I'm not really going to say too much about the first section, except to reiterate the disappointment that many of us have that the very encouraging words of the preamble do not seem to manifest themselves in any concrete plans within the bill to bring some very important new initiatives into our system, like pharmacare.

In terms of the Ontario Health Quality Council, we feel that it should also be required to report on the extent, or otherwise, that the Ontario health care system complies with the CHA principles of public administration, comprehensiveness, universality and portability, and on issues relating to two-tiered medicine, extra billing and user fees.

During the tenure of the previous government, we witnessed a serious erosion of the ability of the people of Ontario to exercise democratic control over the health care system through democratically elected boards reflecting and inclusive of various community constituencies, service users, patient advocates and health care staff.

In light of that, we recommend that the council should not simply be appointed by cabinet but should be assembled through an inclusive, representative process exclusive of for-profit providers, given their obvious conflict of interest.

In addition to the requirement that the council deliver a report on the health care system on an annual basis to the public, we would also empower the council to make recommendations as to the future course of actions to be undertaken.

In terms of opting out and extra-billing, we support a ban on extra-billing and opting out. However, the act must be amended in order to assure that it is absolutely unequivocal in this regard.

My main remarks will be around queue-jumping, particularly as they relate to privatization and health care. We commend the inclusion of this section. However, we maintain that this section must not be limited to insured services. As the list of medically listed services is restricted, this provision would not protect those seeking delisted or as yet unlisted services from queue-jumping.

The major threat, however, is the systemic shift from public to private for-profit health care services. Currently, the most insidious form of this privatization is what is termed public-private partnerships, or P3s. The P3 projects of the previous Conservative government in Brampton and Ottawa, along with seven others in various stages of planning, continue to be advanced despite promises made by the new Liberal government during the election and must be immediately halted, along with the delisting of services. The consensus seems to be that minor contractual changes announced by the government in November 2003 do not substantially change the character of these P3 projects.

Despite claims by P3 proponents that such projects are cheaper, a five-member panel of economists, including former TD Bank chief economist Doug Peters and a former director of audit operations for the Auditor General of Canada, Lewis Auerbach, concluded the Royal Ottawa Hospital redevelopment will cost the public at least 10% more than a hospital built in the traditional manner. The ROH admits it has already spent \$8 million planning and negotiating the P3 deal, far in excess of traditional hospital procurement costs. The estimated cost has already risen from \$100 million to \$132 million. The hospital's projected operating cost savings, if any are actually realized, will not be the result of the private sector's greater efficiency but will result from the planned 30% reduction in beds. Typically, P3 projects which claim to cost less achieve these savings by building smaller hospitals and reducing services.

More recently, another member of that five-member panel, Canadian Centre for Policy Alternatives research associate Armine Yalnizyan, in a February 11, 2004, report to the pre-budget consultations estimated that if the P3 approach is adopted, the additional costs to taxpayers to finance the infrastructure needs identified by the Ontario Hospital Association could reach \$1.8 billion over a typical 30-year amortization period. The additional cost of private financing to the taxpayer for the two P3 projects that are reportedly set to go in Brampton and Ottawa is estimated to be in excess of \$7 million annually. Surely such vast sums of money are better spent in the delivery of health care services. These un-

necessary costs will necessitate either higher taxes or further reductions in service. For every \$1 million of taxpayer money that will be spent unnecessarily on the added costs of private-sector financing, the ROH could pay the salaries of 20 much-needed health care workers for one year.

In her brief, Ms Yalnizyan presents very compelling arguments related to economies of size and the consequent ability of government to command the best interest rates, without the need to raise equity as the rationale for public funding of infrastructure projects. With interest rates at 40- to 45-year lows, it would appear prudent to seize this opportunity to make an investment in the renewal of hospital infrastructure.

Inasmuch as Bill 8 endeavours to assure greater accountability in Ontario's health care system, it is important to take note of the many criticisms of P3 projects concerning their lack of transparency and accountability. It appears now that Ontario taxpayers will not see the contracts for the Brampton and Ottawa P3s, despite promises to release this information in December 2003, until the deals are signed, sealed and delivered.

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Despite accounts of failed P3 experiments both domestically and abroad—public audits in New Brunswick, Nova Scotia, PEI, the UK and Australia have all been highly critical—proponents continue to extol the virtues of the model, inviting Ontarians to go down a road other jurisdictions have already abandoned. British companies like Carillion, a member of the successful P3 bidder, Healthcare Infrastructure Co of Canada, both in Ottawa and Brampton, are eager to import the P3 model, termed PFI in Britain, and are bidding on projects across Canada. However, in addition to the extra financing costs associated with P3s, reductions in beds and declines in services have also been reported; among such reports the review by researcher Alyson Pollock published as a series of five articles in the prestigious British Medical Journal.

So if P3s are associated with increased costs, bed reductions and a decline in service quality, what is the attraction? It is not difficult to discern the interest of the private sector, which perceives health care as a huge untapped source of profit. For governments, P3s are a seductive means of hiding government debt in a deficit-phobic political climate. Under current accounting practices, governments are not required to include the P3 debts associated with privately financed projects in the calculation of its debt, making such arrangements irresistibly attractive to governments anxious to appear fiscally responsible. The irony is that in this effort to appear fiscally responsible, governments are anything but.

I just want to refer to a recent article that was published in the current issue of the *New Yorker*. It's a review of the P3s that the British government has undertaken. It's not an indictment of P3s, but rather, it identifies situations in which they do not make sense. The situations they describe are where service is a natural

monopoly, which describes our health care system—I hope into the future—and where the contract is for an unreasonably long period, which is clearly the case in both Brampton and Ottawa. It goes on to point out how much money can be wasted on consultants beforehand and on lawyers later. In the first case, to try to pin down the risk-transfer issues, and in the latter case, to argue about them if they do occur.

As a result of the policies of the previous government, private stand-alone clinics such as MRIs and CTs operate outside the public medicare system and drain money from it through third-party billings, depriving hospitals of lucrative revenue. More importantly perhaps, such private clinics poach scarce reserves of skilled staff from the public system. They further enable queue-jumping for so-called medically unnecessary services. I want to give you an example from our own region where, in Kingston, there is a private MRI clinic. There's a critical shortage of many of the health care professions in Ontario, including that of registered technologists. Despite advertising across the country, the private clinic was unable to attract a candidate. Ultimately, the private clinic poached a technologist from the acute care hospital, the Kingston General. As a result, the waiting list for critically ill patients in the hospital grew, while those seeking medically unnecessary services could simply jump the queue at the private clinic. Private clinic work is far less challenging than dealing with critically ill hospital patients and can be very attractive to overworked, underpaid, stressed-out health care professionals who may be unable to resist the lure of the private sector, further undermining our public health care system.

I'm not going to say anything about home care, because my colleague Sue McSheffrey is going to address that very well this afternoon.

The drift toward American-style health care, which favours those whose wealth guarantees the ability to jump the queue and receive blue ribbon service, is alarming. Health care costs are a leading cause of personal bankruptcy south of the border. A recent *New York Times* article stated that 43 million Americans are uninsured, more than the entire population of Canada. The same article exploded the myth of private sector efficiency, reporting that health spending has climbed to 14.9% of the US gross domestic product. In striking contrast, according to Sheila Block, health care spending as a proportion of Ontario's GDP has ranged between 5.3% and 6.3% since 1993. Ontario simply cannot afford a private health care system.

I'm going to skip down now to the accountability and compliance directives. The most important and controversial sections that we're concerned about are contained in part III, which appears to confer unprecedented power upon the Minister of Health to require individuals and organizations to comply with whatever accountability agreements and compliance directives the minister determines to be appropriate, potentially including the overriding of legal collective agreements and other negotiated agreements. This constitutes a fundamental affront to the people's rights in a democratic society.

It also raises a lot of concerns for those of us who have lived through and continue to live through health services restructuring. We wonder what the government has in mind: another restructuring of our health care system without having reviewed the one that's already been done, the one that's still unfolding? Many of the directives have not been put into place. At present, we have three people who are facing the loss of their jobs after many, many dedicated years of service to the system due to the transfer of our children's services from the Royal Ottawa Hospital to CHEO. These sections must be repealed in their entirety.

We have been at a crisis point in recruitment and retention of health professionals in our public health care system for many years. Such draconian legislative measures can only serve to drive increasing numbers of health professionals from the public system. If they find, in addition to the high levels of stress they endure on a daily basis, that they cannot rely upon the security of the terms and conditions of their employment into which they have entered in good faith, we can hardly expect them to continue working in the public system.

Here are my conclusions:

This brief attempts to speak both to the strengths and weaknesses of Bill 8 and makes recommendations for its improvement. It seeks to dispel the myth that privatization is the panacea for our health care system woes and demonstrates how in reality privatization has exacerbated the problems in the system. Privatization is neither an effective nor a desirable remedy to Ontario's budgetary problems.

Admittedly, 2003 was not a good year for Ontario's economy. Despite this, corporate profits are up 11.5%, and the corporate tax rate will be 36% for 2004 compared to 40% in the US. We do not have an expenditure problem in Ontario. We have a revenue problem brought about by the Tory tax cuts that will take \$13.3 billion out of government coffers this year alone, more than the combined cost of operating all of Ontario's hospitals. What is required is a return to fair and equitable taxation.

The Tories have left us with not only an economic deficit but also a democratic one. This consultation is an important step toward remedying that. This brief raises objections to aspects of Bill 8, which will surely add to this democratic deficit.

It recommends that the Ontario Health Quality Council not be appointed by cabinet, but rather that it be assembled through an inclusive, representative process exclusive of for-profit providers, given their obvious conflict of interest.

Part III, which appears to confer unprecedented power upon the Minister of Health with respect to accountability agreements and compliance directives, is of greatest concern in terms of inflating the existing democratic deficit. These sections must be repealed in their entirety. Public sector wages have dropped 10% after inflation, and many health care jobs sit vacant. The draconian legislative measures of Part III can only serve to exacerbate recruitment and retention problems, driving

increasing numbers of health professionals from the public system. If health care workers find that in addition to the high levels of stress they endure on a daily basis, they cannot rely upon the security of the terms and conditions of the employment into which they have entered in good faith, they will have little reason to resist the siren call of more lucrative work elsewhere.

The privatization of health care, particularly in the form of P3 hospitals, was soundly rejected by the voters of Ontario. There is a preponderance of evidence, both in terms of the economic analysis and outcomes from other jurisdictions, demonstrating the superiority of publicly built, owned and delivered health care services.

We urge the government of Ontario, in light of our comments, to reconsider this bill. Further, we ask this government to hold fast to its campaign promises to restore our public health care system and to halt its erosion through creeping privatization.

Thank you for instituting this dialogue with the people of Ontario and for allowing me the opportunity to participate in this important discussion concerning the future of our public health care system.

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The Chair: Thank you, Ms Rivier. You've used up about 16 minutes, which leaves us with 14, so let's go with five minutes each. We'll start with the Liberals this time.

Mr Levac: Thank you very much for your presentation. We've heard from many deputations talking about the creeping privatization. I too am concerned about that. What strengths do you think need to be added to the bill in order to prevent it altogether, or to at least send the signal that there must be justification for the types of services that could be provided by the private sector? Are you making a distinction between services provided by hands, or privatization, period, cannot be involved in the public health care system, as we know there already are services provided?

Ms Rivier: There's no question that there's already an involvement of the private sector in our health care system and there are probably parts of that that can be allowed to persist. But the kinds of changes we've been seeing in the last while are very concerning for us. We've seen major destabilizations in home care. We've seen that we have a long-term-care system where we have increasing numbers of private providers, and that the funding for these facilities favours private providers, and not even private non-profit providers.

I have a grave concern about dealing with limited health care dollars and seeing any of that money going into private hands, because the outcome will be of necessity that that means services disappearing. I just don't see our health care dollars increasing appreciably, and to be taking from the little that we have to feed the private sector, I think, is deeply concerning.

Ms Wynne: Sorry; I missed the beginning of your presentation. But as I look at the first part, you talk about the makeup of the council. I'm looking at section 2 in part I of the bill, the appointment of the members of the

council. So you want a representative process. Are you suggesting just an addition to that section of the exclusion of for-profit providers? Is that the amendment that you're suggesting?

Ms Rivier: That's one of the amendments. There are some good things in there in terms of the formation of the council, but I think that needs to be extended to make sure that we are properly representing the various constituencies.

To give you an example of one of the concerns I have, in the steering committees that are implementing the directives of the Health Services Restructuring Commission, there's a requirement that a member of the business community be included in the terms of reference, but there's no provision for front-line health care workers to be involved. These are very important constituencies that have a great deal to offer and mustn't be ignored. Front-line workers have a perspective that I think is critical to understanding how the situation is operating.

Ms Wynne: Do you have specific wording for an amendment to that section that you're going to provide us with, or is that a possibility?

Ms Rivier: I don't have specific wording.

Ms Wynne: If that were possible, that would be great, because it all goes into the mix and then we discuss it in the clause-by-clause, OK? Thank you very much.

The Chair: Ms Smith, one minute.

Ms Smith: With my one minute, I just wanted to make sure that you have some clarifications with respect to the draft of the legislation you've been reviewing. We really appreciate the input that you've made. You've certainly put a lot of work into this presentation, and we really appreciate that.

I don't know if you were aware of the minister's statement on Monday. I hope you were.

Ms Rivier: Yes.

Ms Smith: So you are aware that the accountability agreements that we foresee in this legislation do not apply to collective agreements or to unions—he made that clear—and that there will be amendments brought forward to clarify that. As well, we talked about the fact that accountability agreements will apply to boards of hospitals, between the boards and the ministry.

I wonder, do you have any concerns about the structure of that accountability agreement between a board of a hospital and the ministry?

Ms Rivier: I guess part of the problem I have is that accountability itself has become such a buzzword that the appearance of accountability is not always accountability. But I don't think anybody would disagree in principle about the importance of that. Certainly those reassurances are encouraging.

Ms Smith: Great. With my last 10 seconds—Kevin, I'm sorry. You alluded to the fact that you believed there was going to be a greater proliferation of P3 hospitals in the future. I just wanted to assure you that the ministry is working in concert with the Minister of Public Infrastructure Renewal on a health infrastructure financing and procurement framework that will be applied to any

emerging hospital projects. The framework will be based on the key principles of public ownership, public accountability and public control.

There haven't been any decisions made on any further projects. Certainly with the projects that do exist, we have made very great efforts to ensure that hospital ownership and control remain with the facility. I just wanted to dispel those rumours, should they be out there, that there are others moving forward. I thank you very much for your presentation today.

Mr Baird: Thank you very much, Marlene, for your presentation. It's very well thought out and it's appreciated.

The last time I was at the Royal Ottawa Hospital I was joined by a lot of my colleagues in the Legislature and our new Premier. When he says that they've scrapped the P3 hospital, what does that make you feel like?

Ms Rivier: I think that's been very problematic, because for those of us who are familiar with P3s, as I know you are, it's very clear that what we've seen is a cosmetic change which I think has misled the public. So when you speak to people about the issue they think that's sort of old news. They need to be educated in the fact that these are indeed cosmetic changes, and really, it walks like a duck and it talks like a duck.

Mr Baird: So Liberal, Tory, same old story?

Ms Rivier: I thought you said it quite well when you said that Mr McGuinty's tie may be red but his suit is blue.

Mr Baird: What problem do you have with the contract for this P3 project? I know Mr McGuinty has released it. He said he was going to release it shortly after that comment. What problem do you have with it?

Ms Rivier: Of course, the problem we have is that nobody has seen it. We haven't seen the contract as it was and we haven't seen the contract as it has supposedly been amended.

Mr Baird: Who said you could see it?

Ms Rivier: There was an announcement that the contracts would be released in December. We're still waiting for them.

Mr Baird: In December?

Ms Rivier: Yes, this past December.

Mr Baird: I wonder, because I would like to help you and OPSEU and your members—

Ms Wynne: You're a friend of labour, are you?

Mr Baird: I am a friend of labour. Marlene and I are good friends. Marlene and I get along very well.

I'd like to ask for unanimous consent—because I'm not a member who is subbed in; I'm just here to learn from the deputants—that I could put forward the following motion: That the committee request that the Minister of Health release the P3 hospital contract of the Royal Ottawa Hospital immediately.

Ms Martel: I agree.

The Chair: Does Mr Baird have unanimous consent to make the motion? No, I'm afraid you don't have unanimous consent, Mr Baird.

Mr Baird: They're denying it. They're blocking the release of this report.

Ms Rivier: I thank you for your effort.

Mr Baird: I think it's too bad. We were promised a new era of transparency, we were promised change, but they changed their mind.

Mr Levac: Like the 407—

Mr Baird: You guys said you would be different. You were the Virgin Mary. They would be different.

Mr Levac: We own the bloody thing and we still haven't seen the contract.

Mr Baird: Your government has seen it.

Mr Levac: Eight years to get it.

Mr Baird: You have it now. But you guys were going to be better.

Mr Levac: We are better.

Mr Baird: Marlene, would you do me a favour? Would you give me a call whenever you hear about that contract? I'll give you a call if I hear about it, too. Because I've honestly been trying to get a copy of it. The sad reality is that I'm not sure an agreement has been concluded. They announced something in November. I'm not sure an agreement has been concluded. We don't know if this is an ongoing debate, whether each side has a mountain of consultants splitting hairs over this word or that word. It's too bad that you weren't involved in that process. Thanks for coming.

Ms Martel: There wasn't unanimous consent to allow Mr Baird to place the motion, but I am on the committee so I would like to move the motion, Mr Chair: That the committee request that the Ministry of Health release the P3 hospital contract of the Royal Ottawa Hospital immediately.

The Chair: It has been moved by Ms Martel that the committee request that the Minister of Health release the P3 hospital contract of the Royal Ottawa Hospital immediately. Are you speaking to the motion?

1300

Ms Martel: Yes, I would like to. I think it's important to point out who made the promise to release the contract before December. It was the Minister of Health. It came on the day this bill was actually introduced, so it's appropriate that the motion is being moved here today. It came because the minister that day in November, on the first anniversary of the release of the Romanow report, announced the bill in the Legislature and presented it for first reading. I happened to be at a press conference he was at with Mr Romanow and Mr McGuinty at Hart House earlier that morning and heard him talk in glowing terms about this bill and how it would advance the cause of medicare. I guess he wasn't anticipating the kind of adverse reaction the bill is now getting.

In any event, later that afternoon during question period, the leader of our party, Howard Hampton, said that perhaps the first work of the new Ontario Health Quality Council that was announced in the bill should be to review the contract at the Royal Ottawa Hospital and the contract at the William Osler hospital. The minister wasn't too terribly excited about that proposal. I thought

it was a great proposal, made by our leader, but the minister was not having any of that.

What he did when he said, no, that wouldn't be the work of this particular council because the contracts were going to be released before then, was to say in the House, and it's in Hansard, that the contracts would be released before December. Of course, here we are today, February 18, and we've seen no sign of the contracts. Regrettably, I don't think we're going to see any sign of the contracts until they're signed, sealed and delivered. Of course, then it will be too late to make any changes to them. I think that's the way the government absolutely wants it to be, because what's clear to me is that there has been essentially no change from the P3 model that was first put forward by my colleague Mr Baird's government to the one Mr McGuinty announced here in this community in November. There is absolutely no change.

It doesn't make me feel any better to know there would be public ownership of the hospital when I also know that the financing is going to be private and that millions and millions of taxpayers' dollars that should go into patient care are instead going into the pockets of the two private sector consortiums that are going to build these hospitals. Not only is that going to happen with these two hospitals, but the minister has also been very clear in conversations with others that have been repeated to this very committee that that's the same model the government is going to use for reconstruction and renewal of at least seven other hospitals. The names of those hospitals were actually released in the committee process yesterday in Sudbury by Michael Hurley, who is one of the individuals who had this conversation with the minister on December 17.

So I think that even though the P3 model is essentially the same—a Conservative lease now being replaced by a Liberal mortgage—the people in this community, the people in Brampton, have a right to see the details of those contracts before they are actually signed, in the hope that, since this government doesn't seem to be backing away from the commitment it made to cancel the P3s, the least that could be done is to deal with the more ominous, onerous and repulsive parts of the contract that are going to mean so much money going into private consortium profits instead of patient care.

That's why I'm moving this. I'm glad you mentioned today that you hadn't seen it. That reminded me again of why it was important. Even though Mr Baird couldn't do it, I'm glad that I have been able to move the motion, because I think the public has a right to see this. You're right: The public voted for change. I think they thought the Liberals were going to keep their commitments on ending P3 hospitals and keep their commitments on ending the private MRI/CAT scan clinics, and they haven't done either. None of that appears in the bill, and it's about time we saw the contracts to see exactly what the Liberal government is getting us into.

Mr Baird: I'll be brief. I was convinced by about 18 different lectures and speeches by Gerry Phillips about the need for transparency. I listened and I learned. Gerry

Phillips, in opposition, has convinced me that this is a good thing. Given that Mr McGuinty promised to release it by December, I want to congratulate Ms Martel on her very well worded motion.

The Chair: Very well written, I think.

Are there any members from the Liberal side who would like to speak?

Ms Smith: We believe this is an issue that Ms Martel or Mr Baird could raise in the Legislature when it resumes on March 22, and we believe it's inappropriate to raise it at this time in this committee.

The Chair: Any further speakers?

Mr Baird: This committee has the power to demand it. I'm not demanding. All I'm doing is requesting: Could we please have a copy? We're not demanding it, we're not procuring it, which as a legislative body we have the power to do. We're just requesting it. The House isn't sitting. Mr McGuinty was elected, and he's now taking a 100-day vacation from the Legislature and we don't have question period. This is our only format to try to help OPSEU and Ms Rivier—

Ms Martel: And hold the government accountable.

Mr Baird: —and hold the government accountable for the promises it made. All we're doing is asking, just to let a little sunshine in. The Liberals promised change, and it appears they've changed their minds.

Mr Levac: I'm very concerned about the time this is going to consume, when this particular amendment indicates immediately, and the sensitivity around contracts. Even if I were to take the assumption that the members opposite have implied, that the contract is not complete yet, I've seen companies in my community leave because information was disclosed earlier than it was supposed to be. Quite frankly, it shows an insensitivity toward contract negotiations in general, having no knowledge of what you can do or cost, in terms of the cost to the taxpayer. There could be penalties included in this. I don't even know that at this time. So I would think that assumption itself would be very inappropriate.

The comments that are being made, particularly things like "100-day vacation," show a disregard for the work of all legislators, particularly when we're moving in this direction right now and that people are working as we speak. So in terms of the debate that's taken place on this particular motion, I would ask if we could call the question.

Ms Martel: I do want to say one thing.

The Chair: Ms Martel and then we'll have the question.

Ms Martel: I'll be very brief. I wasn't going to say anything else, but I've been provoked by the comment that this motion displays insensitivity to contract negotiations. Do you know what, Mr Levac? I don't care. I'm much more worried about the public interest. I'm much more worried about how much public money is going to be squandered, going into the profits of the private sector consortium that's building this.

I know why those contracts won't be released until they're signed, sealed and delivered: because then it will be too late to do anything about them. I think your

government should really worry about how much money that could go into direct patient care is instead going into the pockets of the private sector consortium. That's what your government should be concerned about and dealing with.

The Chair: All those in favour of the motion?

Ms Martel: Recorded vote, please.

Ayes

Martel.

Nays

Brownell, Levac, McNeely, Ramal, Smith, Wynne.

The Chair: Thank you, Ms Rivier, for attending today. We certainly appreciate your input.

We stand recessed until two o'clock.

The committee recessed from 1309 to 1403.

CHAMPLAIN DISTRICT HEALTH COUNCIL

The Chair: Ladies and gentlemen, if we can call the meeting to order. If we can have the cameras off too, please. Thank you.

I'd like to call forward the representative from the Champlain District Health Council, Mr Robert Miller. Mr Miller, I'm Kevin Flynn. I'm the Chair of the committee. You've got 30 minutes to make your presentation. You can use that time as you see fit. At the end of the presentation, we'll be using the remainder of the 30 minutes for any questions members of the three parties may have. The questioning at the point will begin I think this time with the Progressive Conservative members, who aren't here yet but I'm sure will be joining us in process.

The floor is yours, and if you would introduce yourself for Hansard.

Mr Robert Miller: Thank you very much, Mr Chair, for the opportunity to appear here today. I will share the presentation of the Champlain District Health Council with the executive director, Kevin Barclay, who sits to my right. In our opening statement, I'll touch briefly on the preamble in part I of the legislation, dealing with the Ontario Health Quality Council. Mr Barclay will discuss the provisions regarding accountability agreements. Those are the portions of the legislation that we've prepared comments on. I'll then close our statement with a comment and a recommendation about the relationship between the district health councils and Bill 8. We'll be brief and to the point, and we very much welcome your comments and questions. We'll try to preserve as much of the time for discussion as possible.

With that, let me very briefly make some comments about the proposed Ontario Health Quality Council. In our written submission, which has been tabled with the committee, we expressed our support and our hopes for the council. I want to reiterate both the support and the hopes. That's the good news. In my statement now, I'd

like to share several concerns and recommendations that arise out of those concerns. Perhaps that's not such good news, but I hope that this will be seen as constructive, in the spirit of improving the legislation.

I have three points that I would make. First of all, the legislation having to do with the Ontario Health Quality Council lacks a mission statement. After reading that part of the legislation several times, I'm still not entirely clear what the mission of the council is. I know that the legislation specifies functions, a function to gather information and to report to the people of Ontario, but that is not the same thing as a clear sense of mission. As all of us know, there is no shortage of monitoring and reporting where health care is concerned, but that has not added up to understanding or accountability between the people of the province and the system.

We recommend that part I of the bill begin with a mission statement expressing in clear terms the principle of democratic accountability referred to in the preamble, the accountability of those setting and implementing health care goals—the government—to the people of Ontario. Approached in this way, part I and part II of Bill 8 can be seen as complementary aspects of strengthening health care accountability.

The second point is a recommendation that the legislation should give priority to “persons from the community” in making appointments. Given our first recommendation, our view of the function or the mission of the council, the second recommendation follows. The council should be made up primarily of well-informed representatives of the community, not experts. Ontario does not need another dialogue consisting of experts talking to experts. We need a vehicle to assist citizens in holding government to account for the achievement of publicly established health care goals. Properly tasked and appointed, the council could be that vehicle.

The third recommendation that I'd make is—and here I will quote—make “helping Ontarians exercise informed accountability” the primary purpose of the council in reporting. There is a list of purposes in reporting; the last listed is promoting understanding among Ontarians. In our view, again following out of the mission statement we recommended to you, that should be the core of the reporting. If the council were to be successful in all other respects, it would still be a failure if it does not strengthen informed citizenship where health care is concerned. Properly understood, informed citizenship should include the responsibility of all of us to act in ways that protect and promote our own health.

That, Mr Chair, is the opening statement. Just to reiterate, our recommendations are that the legislation should provide for a clear mission statement; secondly, following from that mission statement, give priority to persons from the community in making appointments; thirdly, make the central, primary purpose of reporting helping Ontarians to exercise informed accountability over the health care system.

With that, I'll invite my colleague Kevin Barclay to address our remarks concerning the accountability agreements, and then I will briefly close.

Mr Kevin Barclay: In our submission, the Champlain District Health Council has recognized that accountability agreements can act as a foundation for aligning incentives with the desired outcomes. More importantly, council has also recognized that a process of creating alignment between the accountability agreements could provide an opportunity to enhance continuity of care within the system.

Accountability was a significant area of exploration for our council's recent community dialogue process, a process that lasted over the last year and involved over 150 health care leaders. The process engaged leaders from across the Champlain health system toward the goal of establishing a shared vision for health care. It is from this process that we draw our ideas.

In our explorations, accountability agreements have been defined to include an agreement built on trust, an explicit agreement that defines outcomes to be achieved, the supports required to achieve them and the barriers that will be removed so that you can achieve them. Accountability agreements have also been defined to include explicit incentives for meeting or exceeding agreed-upon outcomes, explicit consequences if those outcomes are not achieved, and a balance between accountability and empowerment that allows the organization or individual appropriate flexibility to adapt actions toward improved outcomes.

1410

The accountability agreement provisions of the bill provide a significant opportunity to align incentives with the outcomes that the government and the people of Ontario want and deserve. In too many circumstances, the current maze of incentives and disincentives works against the delivery of quality continuous care.

The bill also recognizes the importance that trust will play in successful accountability agreements. However, trust within the health system has been compromised according to recent polls and the feedback that we've received through our Champlain district process. To this end, our council is presently in the process of facilitating dialogue and action plans related to a theme we call “Care for the Caregiver.” We recognize that a root cause of the challenges we face in health human resource shortages is that pervasive mistrust within the health system. Our experience suggests that successful implementation of accountability agreements will also require building trust at all levels within the health care system.

We also see that to maximize effectiveness within the complexities of the health care system, accountability agreements need to provide empowerment along with accountability. The bill stipulates the importance of clear roles and responsibilities, transparency, a reliance on evidence, and a focus on outcomes. All of these elements will contribute to empowerment.

The complexity of our health care system also requires empowerment that encourages the innovations required to create change. Explicitly recognizing the need for innovation within agreements will empower individuals and organizations to stretch toward achieving the agreed-upon outcomes.

It is appreciated that the recognition of accomplishment is identified within the provisions of the act. Positive recognition is essential for creating the incentives needed for people and organizations to succeed. Such incentives should be incorporated into the accountability agreements at the outset in order to maximize the motivation of the recognition.

To conclude on this matter, the most significant opportunity that we see within accountability agreements is the development of aligned agreements that capture “shared and collective responsibilities” that are identified within the act. Our health care system has evolved from inspired but isolated initiatives into a complex, fragmented maze of services. Individual accountability agreements and other forms of individual outcome commitments will not create a system of care from the perspective of the person using the system. A system of care will only occur when the individual commitments are aligned to ensure that necessary supports are provided and barriers removed by those who share responsibility for quality continuous care.

In our capacity as advisers, planners and facilitators, the Champlain DHC is positioned to create a clear understanding of the interdependencies between the accountabilities of the providers and to facilitate consensus on the collective responsibilities of those providing care. Through the process of accountability alignment, services will build on the contributions of other services and create the kind of quality continuous care the government and the people of Ontario want and deserve.

Mr Miller: In closing, let me add a final recommendation that goes beyond your immediate mandate, and that is that the provincial Legislature should review the legislation establishing district health councils to make sure that it and they complement the objectives of Bill 8. District health councils should be given district mandates that parallel the province-wide mandate of the Ontario Health Quality Council, and indeed the national mandate of the Health Council of Canada. If this were done, democratic accountability could be strengthened at all levels of the Canadian health care system. This is not a problem that exists only at the national level or the provincial level. The issue of accountability is one that applies within our own communities as well.

With that, our presentation is at an end. We welcome the opportunity for discussion. Thank you again very much.

The Chair: That's wonderful. I appreciate your presentation. We've got about 15 minutes left. We'll split that three ways, five minutes each, starting with the PCs and Mr Baird.

Mr Baird: Thank you very much for your presentation.

There are two issues I wanted to raise with you. First, how do you see the quality council that you'd like to see be mandated to the DHCs—how would it interact with the provincial council and then this new national council? How would that work, and how would you respond to a charge that that is perhaps duplication?

Mr Miller: I think the question of duplication is a serious one just because there are so many sources of information and so many agencies. Kevin has told me that just within our district there are something like 160 separate agencies that are somehow or other involved in delivering health care. So there should be a preoccupation with avoiding duplication and building on the work of others.

I think the first step, in answering your question, is that the mission has to be a very clear one. Our recommendation to you is that the core mission of each of those agencies or institutions should be strengthening democratic accountability. It's very easy for information providing and sourcing and discussion to become this expert-and-expert dialogue that I was talking about. But apart from all the other challenges facing the health care system, and indeed all public institutions now in Ontario and Canada, there is this pervasive mistrust, misunderstanding and even cynicism about the ability of public services to achieve their objectives. So (1) it's extremely important that, whether at the regional, the district, the provincial or the national level, there be a clarification of shared objectives; and (2) an agreement on the way we're going to gather and share information to determine whether or not we're achieving those objectives.

The reason for my last recommendation is precisely to make use of an instrument which is already there, which the province of Ontario already spends money on—the district health councils—to supplement and complement this new body.

Mr Baird: Moving to another area, the throne speech presented in March talked about dual accountability. I strongly support accountability mechanisms. I think they're a good thing. I'm glad to see that we're all talking about this, because it is important. I think most people wouldn't object to forms of accountability. I certainly prefer the meaningful accountability.

One of the challenges—this isn't a political statement; certainly it's the case now and it has been the case for the last 20 or 30 years—is with respect to what accountability a government, or the Legislature, has when it puts on limitations, whether it's on revenue sources through the Canada Health Act, whether it's if the government, the executive branch, is going to put accountability mechanisms on the hospitals, long-term care or whatever in eastern Ontario. What sort of accountability do they have? “We want you do to X,” but what's Y? What is expected from them? Do you think perhaps the regional office of the Ministry of Health should have an accountability mechanism to you, to the agencies within that region?

Mr Miller: I'll invite my colleague to comment on that. I won't attempt to answer the question of whether the regional office should do it. The key point I'd pick up in your question would be the importance that there be mutual accountability. It's very easy for accountability to be a new term for an old mechanism, which is essentially command and control. It's extremely important, if accountability is to mean what it should, that it's a way

of bringing people together around shared goals and objectives. This is certainly important in the health care system.

As Kevin has said in his presentation, it's very easy to revert back to a traditional way of trying to exercise accountability. All the evidence we have now is that even if you can enforce those agreements, put them in place and so on, at the end of the day they're unlikely to be effective because there are too many ways available to people to frustrate objectives which aren't shared.

On the role of the Legislature, we have a well-established mechanism in our society for accountability, namely elections. The problem is complementing that process with reliable and trusted sources of information about whether goals and objectives are being achieved, because that too gets caught up in the political process. I think the debate about the fundamental goals of the health care system will be improved, strengthened, if we also have a mechanism that can build some kind of consensus as to whether or not goals are in fact being achieved. That's where I see something like a health council at the national or provincial or regional level being a useful supplement to the political process.

1420

Ms Martel: Can I return to the first point that Mr Baird started on? I apologize that it still is not quite clear to me what your objective is. I appreciate that you want to have the government make use of DHCs to provide any assistance that would be necessary to the council. I'm not clear what would be required, in terms of a change in legislation, to allow that. I would just think that if there's information to be shared and 10 things to be done, that could be done now, with the current structure. So maybe you can tell me what it is that would need to be done. I still have a concern, though, that there would then be some duplication. There aren't enough health resources to go around now. I wouldn't want to see that happen and I don't think you would either.

Mr Miller: Well, I agree with that. The essential change I think is to make the mandate explicit. One of the problems that faces DHCs is that their mandate has been defined in very, very broad, general terms as advising on virtually everything from time to time that the minister may require advice on or that we may deem necessary. That gives the DHCs some flexibility, but absent some clear directions as to what would be useful or effective, it can also leave DHCs floundering out there in this vagueness. So the purpose is not to have the DHCs do what this quality council does, but to bring to that work a specifically regional dimension or focus.

The Champlain district is a distinct district in the mix of rural and urban in the demographics of the district, of the growth of the district. Whereas the quality council can, if you like, develop a broad framework and report on the health status of Ontarians, there is this complementary thing of relating that to the particularities of each of the districts of Ontario. I see these two things working together.

I'm not suggesting that the DHCs need more resources, that they need more staff, that they need more of any

of that. We have the resources to do it. It's more a question of clarifying the mandate and inviting the opportunity for effective collaboration between us and this new mechanism.

Ms Martel: Regarding the point above that, number 3, "Make 'helping Ontarians exercise informed accountability' the primary purpose of reporting," I'm not sure if I do understand. I think there's any number of people out there who would have a sense of what was needed and who would want to assume some responsibility for that. My concern continues to be around the whole notion of the council, that they will do some good work monitoring and reporting, and then it's going to stop at the report stage and there would be no implementation of what necessarily came from the reports. Because they don't have a mandate now to actually make recommendations; the only recommendations the group can make is future areas that they should report on. I think that's lacking. I think they should be able to make very clear, concise recommendations about what they find. So it's not clear to me, when you talk about number 3, what that's going to do to essentially change health care in the province, to move us beyond reporting and to actually move us to some action based on the reports.

Mr Miller: I guess the first requirement is to address the kind of confusion that we sense, in contact with the community, that exists about the nature of the system and the way it works. Individuals approach the system with their own needs in mind. They're either well served or they're not well served. But in addition to that, people are citizens, and they're trying to arrive at some kind of informed judgment about the way the health care system in Ontario or in the area where they live is working. I would say that the average person in our society, and I include myself in that, finds it extremely difficult to form a picture of what this is about, what it's attempting to achieve, and therefore what a basis is for evaluating whether or not it's succeeding. It's not clear to me that the primary function or mission of the proposed Ontario council is to assist citizens in making those kinds of informed judgments.

People in the system have all sorts of sources of information, and they can align that information with their institutional interest and so on. What's much more difficult is for the citizens in general, the people out there who are looking at this debate, these discussions and so on, and deciding, answering a very simple question: What are we trying to achieve here over the next few years? What are we trying to improve as a society? Second, are we succeeding or are we failing? Certainly, in my conversations with people, I get the impression a lot of people find it extremely difficult to answer those kinds of questions.

Ms Smith: Thank you very much for your presentation; I really appreciate it. I appreciate that you represent a large area. I've travelled most of your district, actually, in the last couple of weeks on my long-term-care review, so I'm familiar with a lot of the hot spots along the way. There is certainly some great innovation happening in the

long-term-care facilities in your district. You should be very proud.

I also had the benefit of meeting with my DHC in the last couple of weeks, so I have a better sense of what DHCs are doing. I appreciate the thought you've put into this. We've brought this bill forward for review after first reading in order to allow various stakeholder groups and citizens in Ontario to give us input, and we appreciate the time you've taken to do that, and specifically your input around improvements to the council. The suggestions about the mission statement and the membership are important ones for us.

I particularly appreciated the discussion you just had on what you think the council can do, because I very much see that as how we see the council performing, providing that service to the people of Ontario. There are so many studies and papers being done on quality of care in various areas, and the health field is so vast. I think it would be important to have that one place we can look to that will gather and provide that, and reflect it back to the community so they understand what their tax dollars are being spent on and where improvements are being made and can be made. So I appreciate that we see that in the same way.

Your suggestions on how to integrate the district health councils into that system I thought were important as well. One of the things we're looking at the health quality council doing is amalgamating all of the studies that are out there. I was impressed when I had a list from my district health council of all the studies they've done for my area. I think it's important that we pull all that information together. There's so much good work being done and not being reflected back to the general population. So let's pull all that together and get it back out there. That would be an integral role of the council, and I think that's probably the role the district health councils will play, that filtering up of the information that they're already working on so diligently. So I appreciate that.

You had a question about membership. One of the amendments that we look forward to bringing forward is precluding membership on the council for stakeholder groups. We will be looking at broader representation from the community and actually not allowing people who have executive positions on colleges, boards and stakeholder groups to have a position. I think that will broaden the expertise around the table and allow for a greater dialogue from a community point of view, which is what I think you were looking for.

I think Mr McNeely had a question, but I just wanted to bring one more thing. Kevin, in your presentation you spoke of explicitly recognizing the need for innovation. Was that in section 20, where you were looking at the various matters that can be reviewed in an accountability agreement? There was the "Clear roles and responsibilities." Is that where you wanted some kind of recognition of innovation?

Mr Barclay: Yes. The council has had a number of conversations about the importance of really energizing

that creativity that's going to have to come into decisions that help us change toward a better future. Often it seems as though we think about accountability only after something has gone off the rails. I'm suggesting, and the council is suggesting, that accountability should be something that we take a proactive approach to and include in those kinds of incentives and those kinds of empowerments that will lead to innovation and create positive change.

1430

Mr Phil McNeely (Ottawa-Orléans): Thank you, Mr Miller. One of the issues that came up last fall was inequity across the province. Waiting times were approximately double here compared to Toronto, with less than half the MRIs per capita that they have in Toronto. There were comparisons made all across the province, but certainly those two stood out. Also, the funding of the health care system in the Ottawa area was about 85% per capita of what it was across the province. You must see that, as part of your council.

I am hoping that the accountability also has equity across the province in here and it will change. In Ottawa the explanation you always get is, "You're servicing a great number of clients in Quebec." But that's no longer the case. It hasn't been the case for a few years, yet it has prejudiced our funding here very badly. Do you think the accountability, as it's written here, has equity across the province built into it? Are we looking at the same outcomes across the province?

Mr Miller: I think you raise a good point. Part of the problem with the legislation—it's not something I commented on but it's something I'll mention now—is there is no explicit connection between the preamble of the bill and the provisions for the health council: Does the preamble apply to all parts of the bill? Does it apply to certain parts of the bill? Do certain parts of the preamble apply to the council?—and so on. That's why I'm suggesting that in a mission statement or whatever the health council portion of the legislation should itself have a kind of preamble introduction saying what this is about, what principles it should be guided by. Certainly equity in access is one of those principles enunciated in the preamble.

However, the one thing I would emphasize in a results-based or an outcome-focused quality council—and that is indeed what the council is about—is that the debates about how many of this, how many of that and how many of the other thing are going to be resolved finally by looking at the health care outcomes for citizens. Those kinds of debates tends to become, if you like, a secondary debate about, "Are we being treated equally? Do we need more of this? Do we need more of that?" The bottom line that this kind of initiative, at the national level, the provincial level and, we would say, at the district level as well, is trying to get at is, whatever the differences in the system, at the end of the day, what is the difference in terms of your health and my health, the health of the people in the district? That needs to be the focus for the work of the quality council, and all the other things are then seen as inputs into that. Perhaps you

need to spend more. Perhaps you need to have more of this or less of that.

Sometimes the means to the end become the substance of all of these kinds of discussions and we never get around to the question: What, at the end of the day, is being delivered by these investments, by these institutions and so on? That's what we would like to see at the heart of this quality council.

The Chair: It's not the end of the day but it is the end of your time, unfortunately. Thank you. We appreciate your input, Mr Miller and Mr Barclay.

ONTARIO PUBLIC SERVICE EMPLOYEES UNION, LOCAL 481

The Chair: We move on now to the Ontario Public Service Employees Union, local 481, Renfrew County Community Care Access Centre. We've got Susan McSheffrey, the president of the local, with us today. Make yourself comfortable.

Ms Sue McSheffrey: It might take a while.

The Chair: No problem. While you're setting up, I'll explain the rules. You've got 30 minutes. You can use that any way you like. At the end of your presentation we're going to split the remaining time among the three parties to ask you questions.

This is going to be interesting.

Ms McSheffrey: Show and tell.

The Chair: At the end of the period, you're going to have that time split among the three parties, and this time we'll be starting with the New Democrats. Ms Martel will be starting the questioning. I've got 2:35. The floor is yours.

Ms McSheffrey: Before I start from my prepared text, I'd just like to say I have a deep-seated appreciation for the work you're doing. It's a lot of work sitting here and listening and going across the province. I think from listening in now, you've had a lot to take in and I really appreciate that you've given it the time. Thank you.

My speech: This is my first time doing anything like this, so you'll have to forgive me. I'm really nervous.

It is an honour and a privilege for me to be here to appear before you. I am so happy to be asked for my opinion, actually. It's been eight long years since anyone listened to front-line health professionals, except doctors of course, so I hope you'll forgive my giddy excitement.

I am a physiotherapist with the community care access centre in Renfrew county, just up the valley from here, and I've been there for the past 12 years. I'm part of the brain gain. No one really talks about that, but I chose to come to Canada from Britain 18 years ago because you had the best health care system in the world. I want to tell you that the body of that system is still there. It's a little anorexic but, with some therapy, I think it could soon be restored to its past magnificence.

As well as working as a community physiotherapist, I'm the president of OPSEU, local 481, the professional staff at the CCAC, and I'm a member of the Canadian Health Professionals Secretariat, which links health pro-

fessionals across Canada. I was going to have somebody with me to hold my hand, and that would have been Nancy Surkes. But she got sick, so I'm on my own.

After eight years of uncertainty and instability in health care, we looked forward to the promised restoration of stability and respect for health care workers. Bill 8 doesn't provide any reassurance to us that this will be the case, and I did listen to your discussion on Monday, so I have had a chance to add some of that in. I share Mr. Klees's concerns that we are asked to comment on a bill that is being rewritten as we speak. I can only comment on the information available to me last week, but I recognize that Minister Smitherman provided some clarification on Monday.

Community care access centres—not action centres, as the minister believes—are the daughters of the old home care programs. To highlight some of the gaps in Bill 8, it might help to explain what has happened in my world. Initially—this is where I get my toys out; I do paediatrics—we were all part of the health units. We were sharing space and administration costs in one building. Then came the CCACs, and that doubled; we were created as separate agencies. Then what happened was that all direct service staff was divested, which is really a euphemism for privatized. So the nurses went to three or more agencies, therapists went to one or two, and equipment and supplies went to another. We now have all these buildings with administration costs, lease costs and everything that goes with that, out there in our little community, which is big geographically but not big with people, where we had one before. These separate entities cost much more to operate than when the staff was in-house. For example, in privatizing my service, the therapy service, the cost doubled from \$2 million to \$4 million. It's the same staff doing the same jobs with the same patients. I think it's easy to see why: The overhead and administration costs went up, and profit margins had to be built in.

When local CCAC boards began to cry foul, that this wasn't cost-effective at all, and some even balked at wasting money this way, along came Bill 130. All the CCAC boards were fired and new ones inserted. The fact that every single member of our board was a member of the local Alliance and Conservative riding associations, I'm sure, was just a coincidence.

The result has been a dramatic reduction in service at the client level, as money was being redirected to run all these other organizations. Personal support at home, surely the most effective segment of our health system, has been all but eliminated. For a few dollars a day, the frail elderly and chronically sick were provided with assistance to grow old and die in their own homes. This is what they wanted, and it kept those people out of hospital and nursing home beds. These services no longer exist. Over 100,000 people are no longer receiving care at home, and home care caseloads have been cut by more than a third. Front-line staff have been laid off, while the little fiefdoms we see here are growing in profits and administrators. Just yesterday, and the timing of this is

unbelievable, we heard that three more professional staff at our organization—a social worker, a dietitian and a case manager—are to be laid off on Friday. In the past three years, our professional staff has been reduced by 14.5, while administration and support has increased by 8.5. That's full-time-equivalent people. We're a very small CCAC with a budget of about \$13 million to \$14 million. In-home nursing has been cut 50% and home support by 60%. We've been through six years of turmoil and change, and we are change-fatigued.

1440

That brings us to Bill 8. To me, the most disappointing thing is an absence of the mention of democratic governance, an absence of ending privatization and the absence of a commitment to honour the Long-Term Care Act. In fact, there is very little in Bill 8 that applies to the community care sector.

The preamble sounds so wonderful, and the statement that preservation of our publicly funded health care services is essential for the health of Ontarians now and in the future made me think, "They've got it. Yes. Finally." But further examination was a little bit more disappointing.

Subsection 9(2), opting out and extra-billing, does extend the prohibition against extra-billing by eliminating the right of physicians and other designated practitioners to opt out of the Health Insurance Act and receive direct payments. This does seem to strengthen the prohibition on extra-billing and opting out. But when you read further, in subsection 9(4) there's language that may well open up the possibility of the government itself, through regulation, allowing extra-billing and opting out.

Block fees are a further example of this, and I can tell you that in my rural community these are viewed as extortion. When there are few doctors and you are lucky enough to have one and a bill for \$400 comes through the door, most patients feel compelled to pay. They fear being struck off if they don't. There is no alternative to change doctors because of the shortage of doctors who are actually accepting new patients. For many of my elderly caseload, this is a huge amount of money. The fee-for-service model actually actively encourages this, and the sooner we have physicians on salary, the sooner we can have an integrated system with accountability for the money being spent.

It's our view that block fees should be banned. Block fees are another mechanism to erode the publicly funded system and shouldn't be allowed in regulations or anywhere else. So we support a ban on extra-billing in any form and opting out, and we think the act should specify this clearly.

The superpower being given to the Minister of Health in Bill 8 is very troublesome. Sections 26, 27 and 28 enable interference in workers' rights to decide where to work and the terms of their employment. I do recognize there has been clarification on that with respect to collective bargaining, and I thank you for that.

The violation of free collective bargaining and a worker's right to choose that could happen—maybe just

to divert from my text a little here, I'm not just talking about the collective agreements we have. When this divestment of services happened, there was an assumption that the staff would just go, that they would move with the flow. Many of us choose whom we work for or where we work based on a lot of things, not just the salary—in fact, a lot of us physiotherapists in the public system would do much better in the private system. It's the type of work or the people you work for or the philosophy of the people you work for. To sort of sell people like slaves to the highest, or lowest, bidder has really caused a lot of uncertainty in the health system. My colleague Nancy Surkes is going through that right now with an agency in Ottawa that is being re-divested into three separate groups from one. So it's not just the collective bargaining part but the treatment of the staff who work in the system.

I will say that I think it's true that the government has lost considerable control over health dollars through contacting out to the private sector. Individual contracts, as we learned earlier this morning, are shrouded in secrecy, and the results have not been published so we can make true comparisons with the public system. Fixing problems becomes an expensive proposition, as disputes must be solved in the courts, resulting in lengthy legal wrangling and court costs. Wording that mandates all agencies being funded with public money to account and report publicly for their expenditures will go a long way to facilitate meaningful dialogue. We do have a right to know how and where our money is being spent. This would be an admirable role for the health quality council and would enable the public to read a report card on different aspects of the system.

Given the Canada Health Act principles enshrined in the preamble to this bill, it's surprising that the health quality council, outlined in part I, does not ensure reporting on the way Ontario is doing at meeting those principles. Further, it's not required to report on issues relating to two-tier medicine, extra-billing and user fees.

No person who has a financial interest in for-profit health care corporations should be allowed to sit on the council. It would be a clear conflict of interest. As we read in yesterday's papers, there is a clear example of this in the way drug companies failed to report unfavourable results of their drug trials. Suppressing information that impacts on your business might be a good business practice, but it doesn't pass my taxpayer accountability test.

The appointment of the council by the government is inappropriate for a body that's supposed to increase accountability and objective reporting. Rather than an appointed body, this council should be comprised of a democratically selected group appointed by all parties who represent patients, advocates and people like me who work in the system, as well as so-called experts. The council should include representatives from diverse groups as well as geographically remote areas and equity-seeking groups.

The council should be required to investigate how the health system conforms to the principles of compe-

hensiveness, universality and accessibility. It should be required to report on two-tier access, user fees, service charges and extra-billing. Further, this democratic and representative council should have the power to make recommendations regarding these issues and should be required to conduct its operations in a completely transparent manner.

Part III of the bill needs significant rewriting. In the post-Bill 26 era, there is zero trust in vague language with no explanations. The sweeping powers that the minister is proposing to grant himself are unprecedented. If this act is passed, no one will be allowed to take legal action against the minister or the crown under the provisions of this bill upon its passage. At the same time, the government is free to prosecute anyone not complying with an order by the minister. It's time to bring on the kryptonite and diminish those powers.

Before closing, I'd like to say that our local is an active member of the Ontario Health Coalition and supports their brief to you. We're also active on the Renfrew and District Labour Council and support the position of the Ontario Federation of Labour.

Politicians have tremendous power, and what guides you shouldn't be the interests of large corporations like Extendicare, or even me. What guides you should be the lady at home in Renfrew who's dying of a brain tumour or the little boy in Espanola with muscular dystrophy who needs physiotherapy, occupational therapy and very expensive equipment to reach his maximum potential. This legislation is too significant to blow it. There's a huge chunk of money in the system that could be used more effectively. The best service at the best price is with a publicly funded, publicly administered system. I know this from the results in Britain, and all the evidence at home in Canada supports this, too. Bill 8 needs to as well.

Thanks, and I'd be happy to take some questions, I think.

The Chair: Thank you, Ms McSheffrey. You've taken—

Applause.

The Chair: You have a fan. You've taken 15 minutes. You did a great job. You've left us now with 15 minutes for questions, and we'll start that with Ms Martel.

Ms Martel: Thank you very much. You did a very good job. Without taking anything from the other presentations, it was really good to see the impacts on the CCACs and to have those clearly spelled out. I think it speaks to why competitive bidding in home care absolutely has to be stopped, why we need democratically elected CCAC boards again and why the divestiture should never have happened. What you report here is exactly what happened in my community. Just to give you a bit of an example: In the last round of contracts for nursing services about a year ago, the VON, which has an 80-year not-for-profit history in my community, lost the contract to a for-profit outfit out of Mississauga that didn't even have an office in our community, merely because the VON chose to pay benefits and the CCAC

didn't want to pay benefits. That is why we need to end competitive bidding in home care.

On that note, as I look at the preamble, which talks in glowing terms about home care and ending two-tier, it would seem to me that if the rubber is going to hit the road here, then somewhere in this bill it should say we're going to end competitive bidding in home care. What do you think?

Ms McSheffrey: As an experiment, we've proved that it didn't work. Service to clients is way less but the cost has gone up, and the money has gone somewhere. We know the money has gone somewhere; we can see it. It's in all the—we like to call them fiefdoms, because that's what they are. We lost VON in our community too. VON was the first victim of the competitive bidding process, along with the Renfrew Visiting Homemakers Association, which was a small not-for-profit local business.

1450

Ms Martel: Can I ask you what happened—and I don't want to put you on the spot—in terms of wages and salaries within the system? The other impact of competitive bidding has essentially been to drive down wages and salaries or get rid of benefits or whatever of people working in the system. Can you comment on that with respect to your own CCAC?

Ms McSheffrey: The significant thing has been—and I think the theory was, that through driving down the cost of payments to professionals, you could save money. The problem is that health professionals are in short supply in Canada, so they couldn't really do that. So you've seen the changes in fringe benefits like mileage and compensation for driving. But with the non-professional staff, the home support workers, their wages have dropped by half and they don't get any mileage at all, they don't get any compensation, they get split shifts—all the things that were protected before. So they might get a lady out of bed at seven in the morning and then the next job they have is at three o'clock in the afternoon, giving somebody else a bath or getting them their supper.

Those are the changes, and they've eroded workers' lives. These are real people who have their own lives to live too.

Ms Martel: And who want to perform and provide high-quality health care. It's hard to ask people to provide high-quality health care on an ongoing basis when their benefits are being taken away, when their mileage is being taken away, when their wages and salaries are being eroded, when they're moving from full-time work to part-time and then to casual, which is exactly what has happened in the home care system, not to mention what that does to clients, who need and deserve continuity of high-quality care. It's hard to provide that under that scenario, despite how committed you may be as a health care provider.

I would have hoped the government would recognize the attack that home care has been under in the last eight years and would, in this legislation, bring forward the changes that would end competitive bidding and restore funding to home care, because certainly the restoration of

funding to home care was an election promise. The end to competitive bidding was not a promise, and it should have been.

It is clear that workers have suffered, it's clear that the people who depend on the service are suffering. I'm looking at your extraordinary number of people who are no longer receiving care at home, so now they're going into long-term-care facilities and it's costing all of us a whole whack more money to keep them in a long-term-care facility. And I won't even go into what's going on in long-term-care facilities these days, which has been so public.

If I go from there—you didn't mention this, but I'm going to assume your concerns would be the same. If you move from what's happened to this privatization and look at the privatization of MRIs and CAT scans, which is technology that could be and should be in public hospitals and operated there—the move to private hospitals—do you have a similar concern about what the impacts are going to be, given what you've already seen with the CCACs?

Ms McSheffrey: I think more so from the CCACs. It's my experience in Britain. What we're seeing in Britain is individual institutions trying to get the best deal. My mom needs a knee replacement, and the best deal they could get for a knee replacement wasn't in-house but actually 57 miles away at a nearby hospital that offered them cheaper. So it's a brokered deal in health care.

We joke at work about how next we'll be told that everybody has to have heart attacks on Tuesday, because then you can be cost-effective and bring in the heart experts just on Tuesdays and don't have to pay them any other days. Health care can't be done like that. Best business practices don't always apply in health care. My daughter is a haemophiliac with a rare form of haemophilia. You have to treat those people, even though there's only one of them in an area. You have to make that available. It's not cost-effective, and thank God we have a system that doesn't look at it that way.

Mr Levac: I obviously pick up on your passion and appreciate your teaching tools. I'm a former educator. I know exactly how visuals can help, and they most indeed did.

I'll ask a simple question, and then I'll pass it on to my colleague the parliamentary assistant. It's not meant to be insulting, it's just a simple question. The way you've described it—and I appreciate deeply what you discovered before and are now making very public—do you believe that the public health units in our communities would be the best place for us to provide the services that all of these cups on the table are now broken down to? I think you said at the beginning that that's where our health units did all these things in the first place. Is it your proposal that the cups should be put back into the one spot under this bill?

Ms McSheffrey: Actually, there's a reason I'm not a politician or a lawmaker: I'm a physiotherapist. In the health units, it worked well. We were all involved in

community care. We would meet the public health nurses, who would say, "Look, this lady has just had a baby, and we're worried that he's not meeting his milestones." We've lost that dialogue now; we're all in these separate boxes.

If I could remake the system myself, I would build it more on a CLSC-type model, where you had a community agency linked in with rural hospitals maybe, so that all of the health workers who work in an area would be able to meet each other and there would be some discussion and free flow of people. That's why we elect you as lawmakers and policymakers, to talk to different groups. We're just glad to have had a chance to have some input today, and I hope it's the start of something new, because those of us who work in the system do have some insight. Maybe we don't see the policy side as clearly, but we can certainly tell you how it works on the ground.

Mr Levac: That's great. In the context of the bill, if we could apply it across the board in different ways, still achieving the same goal, you'd be satisfied?

Ms McSheffrey: Exactly, yes.

Ms Smith: I too want to thank you for your presentation. I think it was great. It was very down to earth and gave us some real, firm examples of how this impacts on the real lives of the people you deal with every day. I have similar stories to Ms Martel about the VON in my area and the CCAC and what has happened there, and I think your graphic display has helped us today immensely.

Yesterday we had a presentation where someone was most concerned about the fact that they couldn't get information about the CCAC and the spending there. I just wanted to point out that in the legislation that we are proposing, one of the things that will be a part of it is the accountability agreements between the health providers, which are hospitals, long-term-care facilities and CCACs. There will be a requirement that they be posted and made public.

Ms McSheffrey: Good.

Ms Smith: So those accountability agreements will be made public and people will have access to them, which I think will go some way to answer some of your concerns; maybe not fix the whole problem but at least get some answers out there.

You raised some concerns about subsection 9(4) and about the possibility, by regulation, of allowing extra-billing or opting out. In fact, 9(4), just to clarify, only applies to opting out and, if I'm correct, and I may get the officials to help me on this, it will be prescribed in regulation and it will deal very specifically with areas where physicians are working in hospitals under alternate payment plans and are not billing OHIP but are working on a different system. That allows them to continue those relationships. So it won't be a big window of opportunity; it will be very prescribed, very specific.

I think you've already acknowledged that you've heard the minister speak about the fact that this legislation—

Ms McSheffrey: Yes, there are changes.

Ms Smith: —does not apply to collective agreements and does not apply to unions, and I hope that has calmed those fears somewhat.

You talked about the health quality council and the fact that it does not ensure reporting of the way Ontario is doing in meeting those principles. In fact, I think that is one of the main goals and objectives of the Ontario Health Quality Council, that it will collect the data that is available that is being produced by so many different entities and will provide it to the people of Ontario in order to report back on how we are doing. We do list in the legislation the core functions on access to publicly funded health care. So they are to monitor and report on access to publicly funded health services, health human resources in publicly funded health services, consumer and population health status, health system outcomes and they are to support quality improvement. The things you mentioned that you were concerned about I think would fall under the rubric of those four areas.

1500

The Chair: Thank you, Ms Smith.

Ms Smith: Oh. There you go. I'll answer your other one afterwards. Thank you very much.

The Chair: You were on a roll.

Ms Smith: I was.

The Chair: Mr Klees.

Mr Klees: Ms McSheffrey, thank you for your presentation. I appreciate it very much, particularly the emphasis on home care. The Liberal Party campaigned extensively during the election campaign on their commitment to home care. In fact, if I recall correctly, their long-term vision, as articulated in that election campaign, was to make home care a medically necessary service and thereby effectively underwrite it through OHIP for all of its services. That certainly is a huge undertaking. There are other processes going on now that relate to pre-budget consultations, and it will be interesting, when the budget comes forward, where the order of priority will lie for this government in terms of where they're putting their funding. I'm sure you and many Ontarians will be looking very carefully to see where that promise fits into the many others that have been made.

With regard to your observations on home care, one has—I don't think any political party or any government of any political stripe, and we've had them all in Ontario, sets out to undermine or to destroy a particular aspect of health care delivery. I don't even believe that this health minister had that in mind when they crafted this bill. I give him credit, the benefit of the doubt, and will cut him some slack. It's his first piece of legislation he's bringing forward and obviously it's a learning curve. So we'll bear with that. We are going to be very vigilant to ensure that whatever does come forward hopefully will address the issues that you've referred to, as well as others. Every presentation we've had since we began hearings on this bill acknowledged that it was terribly flawed, that there is an absolute disconnect between the well-intentioned

preamble, which I don't believe anyone would disagree with, and the content of the rest of the bill. Somehow that has to be bridged.

But the issue is accountability, really. Again, no one is going to disagree with that. You agree there should be accountability, and it should be a two-way street as well. The government has to be accountable. So it gets to the heart, I believe, of the point you're making. A lot of money has been funnelled into CCACs, and there is a reliance, then, on the local board, the local chief executive officer, to ensure that that is administered properly. Do you have some advice in terms of what kind of mechanism could in fact be put in place to ensure that we get much more for our dollar, the taxpayers' dollars?

Ms McSheffrey: The best advice is that if you have a board that's made up of people who live in the community, who are from a wide range of backgrounds, and especially clients and/or parents of children who are clients, who are often forgotten as a big part of the CCAC, they will then look at what fits best in their community and say, "We've been getting great service from VON. Even though their bid was slightly more expensive, we're getting better value for money. Therefore, our decision is that we're not going for the lowest price, we're going for the best quality."

What's happening with our board at the moment is that they're looking at equipment and supplies. The prices have increased by 20% in the last year. They're saying, "If we bring them back in-house, we could probably bring the price down 25%." So I think the answer is, it's all accountability; it's the boards, if they represent the people of the area. There has to be some accountability back to the ministry.

Mr Klees: You raise a very important point: the local knowledge. No two communities are alike. It's going to be very different in Ms Martel's area than it is in Ottawa or in York region, for example. So it's important that we have the input from the local community, even more important, therefore, to deal with and extricate the part of this bill that would effectively take away the ability of a local board to make decisions, because what this bill does, as you rightfully pointed out, is place that into the minister's hands and the Ministry of Health then has the unilateral right to make all of those decisions. The scenario that you may well see, then, is that the Ministry of Health determines that in order to save \$500,000 in your CCAC, they will, in turn, decide what the priority services are and how they're to be delivered.

The Chair: Thank you, Mr Klees. Our time, unfortunately, has expired.

Ms McSheffrey: Thank goodness.

The Chair: We do appreciate your coming.

Ms McSheffrey: I even colour-coordinated my report with my outfit today. That's the extent of my knowledge. Thank you very much for your time. Good luck in the rest of the province.

The Chair: Thank you very much.

COUNCIL OF CANADIANS,
BROCKVILLE CHAPTER

The Chair: We now call forward Mr Jim Riesberry from the Council of Canadians, Brockville chapter.

Mr Riesberry, the floor is yours. You've heard the rules. I think you were sitting in the audience. So we'll just let you get comfortable and start when you want to.

Mr Jim Riesberry: Is this water or—

The Chair: That's inspected water.

Mr Riesberry: Members of the standing committee, thank you for the opportunity of making a presentation on Bill 8.

First, a little bit about who I am and my credentials. My name is Jim Riesberry. I'm a graduate geologist and a retired Anglican clergyman. It seems like maybe a strange combination there. I am 70 years old with a wife, three children and five grandchildren and we all live in Brockville. I am here as a concerned citizen of Ontario, a husband, a parent, a grandparent and chairman of the Brockville chapter of the Council of Canadians.

Two years ago I was involved with about 50 others in a door-to-door collecting of over 4,000 signatures on a petition in support of the Romanow report in Brockville and district.

In January of this year I had an angioplasty in which I received a stent in one artery—I thought this would be a good test for it here—five months after my initial visit to the Brockville General Hospital emergency and two and a half weeks after my angiogram. The two procedures are usually done at the same time, but in my case, because there was no bed for me to stay overnight, the two were done at different times, costing both me—since I live 75 kilometres from the hospital, my wife and I needed a motel room for four nights—and OHIP about twice as much. This is one small example of how a shortage of beds can cost more rather than saving us money. In the five months between my visit and my angioplasty, I visited the emergency twice and spent four days in hospital, an additional cost to OHIP due to the waiting time.

1510

Where does one begin to speak to Bill 8 with its grand title, Commitment to the Future of Medicare? I'll begin by comparing it to this little election booklet entitled The Health Care We Need: The Ontario Liberal Plan for Better Health Care. I'm sure the Liberals at least are all familiar with it. I picked it up when I was phoning for Steve Mazurek, who was the local Liberal candidate in Brockville last September. What surprised me with Bill 8 was that it has no mention of many things referred to in the booklet—in fact, I was wondering whether I was studying the right bill at times—such as ending the creeping privatization of hospitals, MRI and CT clinics, the establishing of 150 health teams, home care and mental illness. Does this bill really cover the future of health care in Ontario, or is it just a small start? Hopefully, it's the latter.

On page 3 of the booklet it states, "We will pass a commitment-to-medicare act that will make universal,

public medicare the law in Ontario." Evidently Bill 8 is this act. If you think Bill 8 is going to deal with everything in the booklet, you are sadly mistaken. Let's compare the booklet and the bill.

On page 3 of the booklet it states, "Under our plan, two-tier medicare will be illegal in Ontario." While this high goal is mentioned in the bill's preamble, it is not mentioned in the four parts of the bill. Hospitals still have wards for the poor, semi-private rooms for the well-to-do and private rooms for people like Lord Black. The rich can still jump the lines for MRIs.

On page 5 of our booklet it says, "We will make sure that your health care dollars are invested wisely." Yet the P3 hospitals—we are up to eight now—being built involve fundraising by corporations, which could be done more cheaply by the government, and there is nothing in Bill 8 to stop this. Why would the government get somebody else to finance a hospital when it could finance the hospital more cheaply itself and pay the loan off over the life of the building? It doesn't make any sense. Private financing interest rates are 0.5% to 2% higher than the government would pay. Then the financer would want a profit for his troubles of 5% to 15%.

The new hospital plan is little different from the old Tory one. In fact my wife was visiting her doctor the other day, and the doctor's view was that Liberals just took the Tory plan and made it theirs to have it out by November, sort of thing. I don't think that happened, of course.

The Royal Ottawa spent \$8 million on lawyers alone, putting together a P3 deal. P3s are bad. They cost more by an estimated 10%, and they cut staff and beds—the British Medical Journal says they cut staff by 26% and beds by 30%—to make room for higher borrowing costs and profit. They reduce democratic accountability, using commercial confidentiality to keep financial information and performance data away from auditors and of course from the public.

There is nothing in Bill 8 to stop P3s in Ontario, in spite of the terrible reports we get from Britain, Australia and the USA. Private health companies have a terrible track record. Also, the MRI, CT and dialysis clinics that are for-profit include paying shareholders a healthy rate of interest on their investment. They are still in existence five months after the election, nor are they threatened, or even mentioned, by Bill 8.

On page 6 of the booklet it reads, "We will cancel the Harris-Eves private clinics and replace them with public services." Bill 8 does not do this. In fact, in the bill it refers to paying "health facilities," "provincially funded health resources," "health system organizations" and "entities," all of which could be for-profit MRI, CT, dialysis or other diagnostic clinics. If such for-profit clinics are not to be funded by OHIP, it should be made perfectly clear in Bill 8. It isn't.

On page 7 of our Liberal election booklet we read, "We will deliver better family health care through family health teams." The phrase "family health teams" doesn't show up in Bill 8, not even in the preamble.

On page 9 of the booklet it reads, "We will invest in home care so that Ontarians can receive better care at home." Again, home care is not mentioned in Bill 8, and when I contacted the home care office in Cornwall, the staff knew of no impending change. As an Anglican minister, I visited the elderly in their homes. Often I would meet homemakers making meals and cleaning house. Correct me if I'm wrong, but that work doesn't seem to be financed by the government any more but, in Brockville's case, by the Red Cross through the VON.

On page 10 of our booklet the government promised, "We will build a seniors strategy that guarantees our seniors will be treated with respect and dignity." The recent abuse reports in the news of residents in nursing homes makes us wonder when that strategy will be coming. It is not in Bill 8. The hours of care per resident in nursing homes and long-term facilities have shrunk and are inadequate. Bill 8 says nothing about them.

Can we have confidence in for-profit nursing homes? I think not. I lived in Cochrane, Ontario, from 1987 to 1998. Around 1995, Extendicare simply pulled out of Cochrane to go to Stoney Creek, where it could evidently make more money. It simply left Cochrane with no nursing home. For-profit nursing home facilities are being encouraged at the expense of public ones.

Instead of talking about adding to the list of drugs covered by OHIP for seniors, the government is thinking of giving financial means tests and cutting out the universality of the program. Bill 8 refers to catastrophic drug costs in the preamble, and that is the last we hear about it in Bill 8.

On page 11 the booklet says, "We will help families struggling with mental illness." Mental illness doesn't even get a mention in the preamble, nor does the promise of more doctors and nurses.

But enough about what is in the booklet and not in Bill 8. Perhaps we should look at what is in Bill 8.

There is a lot in Bill 8 that concerns me and many others, including the medical unions, which I understand have taken a strike vote in case the bill goes through. To begin with, I loathe being referred to as a consumer of health care. This is done repeatedly in the bill, and I wonder whether an attempt is being made to set us up for for-profit health care, as if going to the hospital is like going to the mall. To my mind we are people, human beings, patients, individuals who at times need health care and have a right to health care. We are not consumers of health care, some of whom have more money to spend on it than others.

The council: At least the council is in both the booklet and the bill. I think that a person who has a financial interest in a health system organization should not be a member of the Ontario Health Quality Council. There should not be a hint of conflict of interest. A second look should be taken at who appoints the council. Should it be elected? In clause 4(a) there is a list of things to be monitored by the council. Conspicuous by its absence is its responsibility to monitor for-profit creeping privatization, in spite of the Liberal promise in the booklet to end it.

Accessibility: I am worried about the term "a health facility," which evidently, by definition, is the same as "a practitioner," either designated or non-designated. This definition of a health facility appears to open the door to for-profit, private clinics to be funded by OHIP, as are doctors. For example, on page 11 of the bill, subsection 14(1) reads "At the request of the general manager, any person or entity"—now a for-profit health facility is an entity—"that provides a provincially funded health resource...." Where we read "practitioner" or "entity," can we now read "for-profit health facility"?

1520

Again, back on page 8 of the bill it reads, "The minister may enter into an agreement with a specific person or organization other than an association mentioned in subsection (2);" that is, the doctors', dentists' and optometrists' associations. Would such an organization be a for-profit health care one? It doesn't say.

On page 12 it refers to a provincially funded health resource as meaning "a service, thing, subsidy or other benefit funded, in whole or in part, directly or indirectly, by the province." Can this provincially funded health resource be a for-profit enterprise? It doesn't say.

Are block fees paid in advance for possible uninsured services a good thing, as advocated on page 3 of the bill? I don't think so. Why should we have to gamble on our health with a doctor who is far richer than most of us? Sure we can change doctors, they say, if we don't like our doctor's block fees. Lots of luck trying to do that.

Accountability, part III on page 15 of the bill: A health resource provider is defined as meaning "any corporation, agency or entity that provides, directly or indirectly, in whole or in part, provincially funded health resources...." Can it be a for-profit corporation, agency or entity? It doesn't say.

In summary, what is wrong with for-profit privatized health care? All doctors are for profit.

First, according to the Romanow report, other studies and from common sense, it doesn't save money. It costs more in the long run. The experience of Britain and Australia confirms this.

Second, it relies on cutting corners in construction, in maintenance, in service and in wages to make a profit. In the case of P3 hospitals, few boards can afford to pay lawyers out of operating funds to sue when a problem arises. When health service is cut, patients suffer. We see this especially in nursing homes and long-term care. In for-profit facilities we see two managements, one for health care and one for profit. Sounds like great fun.

Third, the Liberals got elected by promising us publicly delivered health care that does not have operating money being siphoned off continually as profit.

Listen to a letter I received on January 8 from Premier McGuinty, when I asked him to clarify whether or not the P3 plan was the same or different than the Tories' plan. I quote:

"The new Royal Ottawa and William Osler hospitals will be built as open and accountable hospitals. Under the new agreements, the hospitals will remain in public

hands and be owned by their boards, which will direct all work by the private contractors. In addition, the agreement will be made public, and the public will also have full access to services at the new hospitals."

Sounds great. Unfortunately, Bill 8 doesn't support the impression this letter gives. Neither the bill nor the letter says who will borrow the money for the hospitals, or who, besides the contractor, will make a profit.

If I had to choose between the Liberal election booklet and the Liberals' Bill 8 for the future of health care in Ontario, I'd choose the booklet.

The Chair: Thank you, Mr Riesberry. That leaves us with about 13 minutes, so why don't we give each party five minutes, starting with the Liberals.

Ms Smith: Thank you, Mr Riesberry. Let me first just confirm for you that in fact this piece of legislation is but a start to our changes to health care in Ontario. So you can be assured that there was no intention of trying to fulfill all of our promises in this piece of legislation. I would, however, point out that on pages 3 and 4 of our booklet we are making headway and we are certainly meeting a number of the objectives that we set out there, saying that we would pass a commitment to medicare act that will make universal public medicare the law in Ontario, and that is what this is intended to do. We believe that all Ontarians should have access to medically necessary health care services based on need, not on ability to pay, and certainly that remains our intention.

Also, on page 4, we outline that we will report directly to the people of Ontario on health care, because we believe the people of Ontario have a right to know what their health care system is doing. That's exactly what the council is being constructed to do. It goes on in more detail. I won't repeat the rhetoric, but certainly that's what the council is intended to do and that's where we're at.

I'd just like to clarify a couple of things you stated in your presentation. Your concerns about P3 hospitals, that there were now eight P3 hospitals in the works: In fact, you have the words of the Premier with respect to the two hospitals in question and there are no other hospitals in that same structure right now. No decisions have been made with respect to the other six or seven hospitals that you refer to.

In fact, the ministry is working in concert with the Ministry of Public Infrastructure Renewal on a health infrastructure financing and procurement framework that will be applied to emerging hospital projects. This framework will be based on the key principles of public ownership, public accountability and public control. As we have stated in the past, we are against private hospitals and we will continue to work toward finding solutions on the construction of those next projects.

You raised the issue of private MRIs. Again, we're moving toward bringing them into the public realm. That will take some time but it remains one of the commitments of this government, and hopefully, over the next four years we will see those things happening.

You raised, a couple of times, something that's near and dear to my heart. I'll just comment on it and then I

know one of my colleagues has a comment. You did talk about nursing homes and long-term-care facilities. I'm presently reviewing nursing homes and long-term-care facilities across the province. I was requested by the minister to do that. I've taken two weeks out of that to do Bill 8, but I'll be going back to that at the end of next week. Certainly we hope to see some major improvements in our long-term-care facilities across the province after we bring back some recommendations. So far, I've visited over 20 across the province and have spoken to front-line workers and stakeholders. We're doing as full a review as we can in a short amount of time so we can bring some improvements to the system.

I'm pleased that you agree with the concept of accountability. I'm going to try to provide you with some clarification about section 14, but maybe I'll just go back and look at my notes and let my colleague—

Mr Ramal: Actually—

Ms Smith: Did I address it already?

Mr Ramal: Yes, all the points.

The Chair: Ms Wynne, you've got about a minute and a half.

Ms Wynne: Just a quick question. Thank you for your presentation. You mentioned a little bit about the council. The council is sort of a centrepiece of this legislation—the legislation isn't intended to do everything we promised. You've said who shouldn't be on the council, but as it's laid out in the legislation, are you generally satisfied with the way the composition is laid out, or do you have suggestions about who should be on that council in order for it to work and report on the health of health care in the province?

Mr Riesberry: I think I'd agree with my predecessors that we don't just have experts on the council.

Ms Wynne: So community representation would be important to you.

Mr Riesberry: Right.

Ms Wynne: If there's anything more specific that you think of on that, you could let us know.

Mr Riesberry: I have a question. There's talk about Osler and Royal Ottawa being public. I guess the basic question is, who is going to borrow the money? Is the corporation going to borrow the money or is the government going to borrow the money?

Ms Wynne: You've got the information from the Premier. I don't know if the parliamentary assistant wants to comment on that.

Ms Smith: I don't have any more information than that.

But I did want to go back to your presentation. I did remember what it was that I wanted to clarify. You were concerned about the definition of "entity." I just wanted to assure you that as we are looking at amendments we are looking at clearly defining what entities will be covered under very specific parts of the legislation. I think you'll see that coming forward in the next round, after we've had a chance to bring forward some amendments, some clarification.

The Chair: We can move on to Mr Klees.

1530

Mr Klees: Thank you, Mr Riesberry. I would be very interested in how the geologist and the pastor came together at some point. I'm sure there's an interesting story there.

Mr Riesberry: Maybe it had to do with mosquitoes and black flies.

Mr Klees: I see.

Mr Riesberry: Levity.

Mr Klees: I was interested in the letter that you received from Mr McGuinty regarding his apparent reaffirmation that there would be no P3s under his administration. You're a learned gentleman and you see through rhetoric. I think you've gone to the heart of what a P3 is: Who pays? It's either paid for with public money, underwritten by government, or the private sector. The parliamentary assistant couldn't answer your question. I'm not sure you were here earlier when my colleague put forward a motion to this committee that I think would help us certainly get to the heart of it. In the interest of being open, an open government, the motion read: "That the committee request the Minister of Health to release the P3 hospital contract for the Royal Ottawa Hospital immediately."

Having full disclosure of that contract would certainly let you and everyone else in the province know immediately whether or not this, in fact, is a P3—call it what you will—and to see whether or not there is a follow-through on the promise that was made. I wasn't here at the time, but I understand that Mr Baird and Ms Martel voted in favour—I think it was actually moved by Ms Martel—and that the Liberal members of this committee voted against that. I would be very interested, as I'm sure you probably are, to have an explanation from the parliamentary assistant as to why each Liberal member of this committee voted against that motion. Shall we take the time to hear that. Ms Smith?

Ms Smith: I don't believe it's your prerogative to be asking questions of us. I believe this is the time for Mr Riesberry to provide us with information. Perhaps you have some questions you'd like to ask him.

Mr Klees: Perhaps. Well, no, actually, that's not true. It is my prerogative to have a dialogue. It's my time. We have the right, as members of this committee, to direct questions in any way. Through Mr Riesberry, who said he's very interested, I would ask you again: Could you give us an explanation?

The Chair: Certainly it can be asked. It doesn't have to be answered.

Mr Klees: That in itself will be an answer.

The Chair: That's fine. That's how the rules work.

Mr Riesberry: I find it interesting to find myself agreeing with a PC member of the provincial government.

Mr Klees: As the world turns.

The Chair: Maybe one of you has moved.

Mr Klees: When you're on the side of justice—thank you. I have no further questions. I thank you for your presentation. I think you have touched a very sensitive

nerve. We're all going to be watching very carefully, as I'm sure did the many who did as you did, support your Liberal candidate, voted for a Liberal government that is turning out to be something very different than was represented on the campaign trail.

Mr Riesberry: This is the worry. I even did phoning for a candidate, as did my wife. I put an NDP sign up too, as a matter of fact.

The Chair: Ms Martel, that's a good opening.

Ms Martel: It is. But since we don't follow you behind the ballot box, we don't know what you actually did, so we'll just leave it there. How's that?

I thought your presentation was very good because, frankly, what it did was point out the huge contradiction between what was promised by the Liberals during the campaign and what is now being delivered. Let me start by your very last sentence, which said that if you "had to choose between the Liberal election booklet and the Liberals' Bill 8 for the future of health care in Ontario, I'd choose the booklet."

Many people did choose change. The Conservatives are gone, the Liberals are in government, and people are still waiting for change. They're not going to get it in Bill 8 because if you really look at what the bill does—and you've articulated it very clearly. Let me give you my take on what it does. You've got part I, which sets up a quality council whose sole function is going to be to monitor and report on health care outcomes. They've got no responsibility to even make a recommendation to the minister about what changes should come. We've got lots of people making reports, and those reports get shelved. I have a great fear that that's exactly what's going to happen to this council.

Part II is what used to be the old health services accessibility act. It's an act that was already in place. It has been essentially lifted and put into this bill with a few changes. So there's very little that's new in part II.

Part III is the sledgehammer provisions where the Minister of Health takes over control of hospital boards when he wants, wherever he wants, at any time that he wants and for as long as he wants.

So there's Bill 8, with the exception of the preamble. Who could argue against the preamble? Nobody in Ontario. Maybe there are some who really believe in private health care, but by and large Ontarians look at the preamble and say, "Yes, we want medicare. That's what makes our country different." When I'm really cynical, I think that Bill 8, the preamble itself, was really set up as a public relations exercise. I don't think it's any accident that this bill was introduced in the Legislature on the first anniversary of the Romanow report; I think it was no accident at all. The government has continued to use the preamble as a cover for the rest of the bill, most of which is not new, and other parts of the bill have provisions that nobody wants.

If the government was serious about giving effect to the preamble, then somewhere in this bill there would have been some provisions to implement what was in the booklet. Let me give you an example. If stopping P3s

was a priority, and it certainly was promised by Mr McGuinty, who said really clearly he was going to stop P3 hospitals, that would appear in the bill. It doesn't. If it was a priority for this government to cancel the private MRIs and CAT scans and put that equipment into public hospitals, that would be in this bill, because they promised it, and it's not. If it was a priority to improve home care, then the government would be ending competitive bidding in home care. Although home care is referenced in the bill, there's no provision to allow that to go into effect.

I regrettably see the bill, announced on the anniversary of Romanow, as little more than a public relations exercise from a government that would like to claim that they are doing something to support medicare. But when you look at the details, you see there are no provisions whatsoever to actually do that.

You didn't get an answer to your question about whether the private corporation is going to be borrowing money. If it wasn't going to be the private corporation borrowing the money for the Royal Ottawa, we wouldn't have negotiations going on right now with the private consortium to put the deal together. If the government, using public money, was going to fund this, then they would have been saying, "The deal is done. You can go away now. We're going to build this." You haven't heard that announcement because that announcement is not coming. You're darn right this is going to be paid for by the private sector, and the taxpayers are going to pick up the costs for the very reasons you mentioned.

It costs more for the private sector to borrow money than it does for the government, and the private sector isn't going to do it for free. They're going to want 10%, 15% or 20% profit off the top. So in the mortgage arrangement that the hospital is going to get stuck with, taxpayers are going to pay a whole lot more, because it is going to be the private sector who's building. That's money that should be going into patient care, not into the profits of the consortium.

As I look at this bill, and as I read what you had to say, which was very good in pointing out the difference between the promises made and what's being delivered, I think at the end of the day we have a bill that was big on public relations, given the date it was announced, but very short, frankly nonexistent, in terms of any provisions that actually support or enhance medicare.

1540

If this was the priority for this government in terms of its health care commitments, we are in serious trouble in terms of what else may, or probably may not, happen with respect to the rest of their promises in their booklet.

The Chair: Thank you, Mr Riesberry. We did appreciate your input. Thank you for coming today.

Just a little bit of housekeeping before I introduce the next person: For members of the committee, the vans will be leaving the hotel at 5:15. There will be two vans. One will be for the people who are getting off in Toronto. The other van will be for the people who are going on to Windsor. It's important that you take the right van, be-

cause you may go one way and your luggage may go the other.

Mr Klees: On a point of order, Mr Chair: In light of the fact that Ms Smith was unable to provide Mr Riesberry with an answer—I understand she may not have the information—I would respectfully request that Ms Smith at least undertake to provide Mr Riesberry with an answer when she's had an opportunity to research this specific question. Would it be appropriate for us to do that?

The Chair: When Ms Smith comes back, perhaps we can ask her. I think it's appropriate to ask.

Mr Klees: OK.

The Chair: The answer of course will be her own.

ELAINE TOSTEVIN

The Chair: We can move on at this point in time to Elaine Tostevin, who may or may not be here. Oh, very good. Thank you for coming, Ms Tostevin.

Ms Elaine Tostevin: It's nice to see a friendly face.

The Chair: Make yourself comfortable. Once you are set to go, you've got 30 minutes. You can use that time any way you like. At the end of your presentation we'll split up the time equally among the three parties. This time around, the PCs will be asking the first question. The time is 3:44.

Ms Tostevin: My name is Elaine Tostevin. I live in Ottawa now because I fled the problems of Toronto, as Kathleen and I have been through Citizens for Local Democracy issues for years. I'm so happy that you are now an MPP.

I have my degree in political science from Western. I was a teacher. I've been involved in many political issues. I work with native artists and promote wholesale their sculptures and their art across Canada. I've driven across a few times. It's a long drive.

So I am quite aware of the concerns of many Canadians, and the top one is medicare. We can't cut it any more than it has been. Any poll, any kind of public opinion research, and I've been involved in some of that, has always proven that issue.

The night the Liberals won, I was so relieved and happy because I had suffered so much under the Tory regime, as so many other people have—disability and other issues. I even campaigned and prayed for Liberals, voted for them, as I have provincially and for Chrétien too. I meant to wear my pin of Dalton. In the long term I trust him, but I hoped for better bills than this.

Some friends were chatting to me about worrying about Ontario going the same route as British Columbia. Before the election, I said, "Oh, no, they wouldn't do that. It's a whole different group of Liberals and a different style." But I still hope they will not allow our treasured legacy of universal health care to slide down the slippery path to the US style of privatized, extremely limited medicare that costs the average American thousands annually for extra coverage, as basic medical coverage covers so little.

I'm also sad about the Quebec Liberals. I was doing my sales calls in Quebec during the election period and doing whatever I could to promote the Liberals. I even chatted with Jean Charest a while before then, before he ran as leader of the Liberals, and he seemed so concerned about the mess in Ontario. So I just hope he isn't going down that same messy path as the Harris regime did.

My degree in political science taught that new parties must change all deputy ministers and assistant deputy ministers immediately, as they set the policy too often and are still promoting the former regime's programs and lobbyists' interests. That's a basic rule for political science.

I was also initially pleased that BC went Liberal, but then they started this trip down the slippery path to privatization, and there's so much pain in BC. There, 6,000 workers have been laid off and 20,000 workers will be laid off. I have a friend who's a manager of a hospital in Abbotsford who had the dreadful job of being forced to cut all these jobs and being forced to deal with the trauma and the pain that the workers were suffering, and then trying to run a hospital with not enough staff. The PPH deal was cutting the quality of the staff so much and giving the six-week trainees important jobs which should have been left to RNs.

So why can't the Ontario Liberals learn from history and evade the mistakes of the other provinces, and other countries in the world? I've travelled widely. After visiting Brazil and Mexico, those mistakes of globalization are so obviously dreadful, with very low-paying jobs, no pensions and no unions to protect their workers from severe abuse and give them medicare, which is very two-tiered, with the poor having little or no health care and thousands of street children who literally die in the streets.

Before I went to the 1992 Global Forum for the environment, I had read that some 83 children had been murdered. I thought this can't be happening, and it's one reason I went. I thought this can't be a situation.

We don't need to go that route, and I'm really dismayed that Pierre Pettigrew is now the Minister of Health, because he and Paul Martin were the architects of globalization.

We need to celebrate the benefits we enjoy as Canadians.

Those hospital workers in BC who used to make \$18 an hour are now making \$9 an hour. Also, after visiting most American cities, I am shocked at the poverty. Everyone complains about the lack of medicare, and they can lose their homes if they get seriously ill even if they have a job with medicare. And they're paying so much more for drugs because they won't allow generic drugs.

I was at the Ottawa Hospital Civic Campus the other day and I picked up this article. It outlines their concerns about Bill 8. I'm sure everyone has gone over all this before about the accountability agreements and compliance directives, which allow the Minister of Health to order a reorganization of health services in a community that allows the ministry to use those powers to order that

all patient records and clerical functions etc be contracted out. That allows a single company to operate all these services for all the facilities for value for money. That's giving too much of a monopoly to probably an American health care corporation, because they're the ones lining up and limo-ing the Tories, anyway, to take over.

I chatted with a CUPE worker, and he thought for sure it was no problem. He hadn't read the paper. He said, "I have a contract that ensures that if I'm forced to go to a privatized company, I will get the same wages and benefits." I said, "Uh-uh, that's not what's happening in BC and Quebec. All they have to do is pass this Bill 8."

So it lets the wages and benefits be cut and pretty well guts the unions, as they've done globally, and in the US especially, though other countries are in much worse shape than even North America and Canada. Why are the Liberals continuing with these Tory injustices? That's not what we voted for.

Referring back to the importance of new governments—I don't know any of your alliances here or your parties, except Kathleen.

1550

Mr Klees: Those are the Liberals over there.

Ms Tostevin: Oh, he's laughing. That's good news.

Mr Klees: It's a nervous laugh.

Ms Martel: He doesn't want to cry.

Ms Tostevin: Referring back to the importance of new governments immediately replacing all deputy ministers and assistant deputy ministers, according to a Toronto Star article written by Ian Urquhart, the architect of this bill is Phil Hassen, a former BC assistant deputy minister who helped design the destructive BC cutbacks. Pourquoi? He was brought into the ministry by the former Tory health minister, Tony Clement, over a year ago. I would imagine this was supposed to be done before the election, but they ran into SARS. I have to congratulate the health care system for how they handled SARS. It's so sad that workers and health care people were killed by that disaster.

The P3s—I'll just call them that, because everyone knows the term—that are determined to build new private hospitals have to be stopped immediately, as the Liberals promised, as they're beginning the privatization of Ontario's health care system. It's a foot in the door. Once they get that foot in the door, NAFTA rules and all these other globalization rules won't allow us to stop the privatization. The Liberals have to be more brave and let the banks, who are definitely expecting a huge profit, take the government to court. Any court settlement will be much less than the huge overruns in English PPH costs, which almost doubled the costs. From their basic estimates, most of the hospitals' costs were almost doubled.

We have to trust the court systems to rule in favour of the public interests and not corporate greed. Hospitals in PEI dropped out of PPHs when they realized the private hospitals would cost significantly more. So why can't we learn from PEI?

Liberal health leaders need to study the British PPH mess that Margaret Thatcher forced on them, and I'm sure you've been hearing all about that. They cut the staff and the beds by 26% in P3 hospitals, and they used much poorer quality stuff. Their hospitals are falling apart.

Savings to public hospitals are made by having government lending rates that are at least 2% to 4% lower than private loans, so why not use it? Sooner or later government has to pay for these hospitals, so why not? That's a big difference in interest rates and costs over the life of a 30-year contract. In Britain, they were actually paying for 30 years and never owning the hospitals, which is totally ludicrous. As a mortgage payer myself, I wouldn't be paying that. I want to own it someday. But because I'm on disability, I've had to lose two houses and gear down. I had to lose my Victorian townhouse in Toronto, go down to a cottage on Lake Simcoe, and then I couldn't even handle that because they keep taking all my money away when I make it. That is so wrong—this is later in here, but I'll do it now—because the \$165 we're allowed to make a month was designed 15 years or 20 years ago, OK? You can't live on \$930 a month. My monthly pay is down to \$700, and I'm allowed \$165. I'm working. They took another \$200 away from me. I like to work a bit. I can't work full-time. I used to be a teacher and work a lot, but I've got—it took me three years to get MRIs on my shoulders. There are totally torn tendons, and I can't even sit or stand without—I'm glad we can sit. Because of all this backlog of—well, because no doctor would believe me—"Oh, you look great." I'm in agony. It also took me three years to get that hip replacement done before this specialist finally did MRIs.

It takes cabinet five minutes to change the \$165; take monthly out, change it to weekly, and the most unlikely person told me this. He was a minister for the Tories. What was his name?

Mr Ramal: He must know.

Ms Tostevin: No, it's not him.

Mr Klees: That's how easy it is. You just do it.

Ms Tostevin: I was doing speeches to save the moraine, and I'm upset about that too. Let them take you to court. Judges will rule for the right thing, not necessarily for the huge realtors.

So he said it takes five minutes in a complete cabinet to change \$165 monthly to weekly, just change one word. You don't have to have hearings, you don't have to spend a lot of money running around the country. That would allow me to keep this third—I'm in a condo-townhouse. For me it's dreadful because of all the stairs, but I couldn't afford anything else.

Mr Ramal: Shameful.

Ms Tostevin: Yes.

Mr Ramal: We're in government now; we can fix these things.

Ms Tostevin: Please, because I'm in the process of actually losing this one.

Interjection: The cheque is in the mail.

Ms Tostevin: No, I want this for everyone, just changing it from monthly to weekly, because there are

people committing suicide, especially in the north where there aren't jobs, because they cannot live on disability and they're too disabled.

For the for-profit MRI and CT clinics, this opens the floodgate, and they've already jumped in and have the huge American multinational companies to privatize health care. The Calgary experience shows that costs were 21% to 25% more as privatized in Calgary than they were as a public system. So why do we follow these mistakes? They're already proven wrong. It's a foot in the door, again, of this multinational corporation takeover of Canada's health care.

Health care is a human right, not a commodity to be bought and sold without conscience or concern for public risk. I find any time I have tests, and I've had a variety of them, in a privately run place, they'll do the same ultrasound or whatever in five minutes. But I have it done at Ottawa Civic and they're very thorough. They'll take at least 20 minutes and you feel that you're being much better diagnosed. The faster diseases are diagnosed, the cheaper and faster the cures are, and that saves the system money.

The Liberals did make a commitment to return these clinics. Now the Ontario Health Care Coalition backgrounder also states that the Liberals promised to review long-term-care facilities, and I would imagine this has been covered quite often. They need to be inspected. I was so happy with my mother's care place. It was the IOOF in Barrie, and it was sort of a public type of system, and they really seemed to care for her and the other patients so well. I've heard such nightmares in the Toronto system where it's more private. Extendicare is being kicked out of different states in the US, but it's taking over Ontario. Literally they've stopped Extendicare from functioning in several states. Read the New York Times. Any of you people who are heavily involved with making decisions, all the Liberal cabinet, please read the Sunday New York Times and the others. I should quote the record. Anyway, this is all written, I'm not quoting every source.

Privatization of health and hydro is a Tory Trojan horse, critics say, as the Ontario Health Coalition and the Ontario Electricity Coalition took their Trojan horse across Canada. Paul Kuhnert and Ken Abram of the electricity coalition have fought so hard to save our public hydro. He actually phoned me—I had signed up to become more involved in it—and said: "You won't believe it. I'm being asked to speak all over the world on how to stop the privatization of hydro." This is a global mess. This is a global problem. We were all so happy about that stop. Now I hear that Dalton McGuinty has travelled to Alberta to study their privatized hydro system, which costs my sister in Calgary three to four times more now that it's privatized. This was never mentioned in the election promises, so it can't be done. It's just not democratic to go totally backward on such an important issue.

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Since the Liberals have cancelled the tax cut bribes to be elected, the \$5-billion debt will be eroded over time.

The Tories were taking us that much into debt almost annually, right, Kathleen? We were studying that. The Liberals should not try to balance the budget quickly. Taxpayers aren't that concerned about an instant balanced budget, because we don't want drastic cuts to public health care or any of our other services. Just let us keep public what hasn't been gutted by the Tories. Privatization is just based on greed and profit, and they always do it by cutting jobs. They take \$9 away from that \$18-an-hour worker, and that's their profit. The 30% bed cut is their profit. But if it's public, it costs half the price for the hospital and the beds aren't cut.

Here are some other hints for budget problems. Why not a 2% tax increase, as suggested by Linda McQuaig in the Star, instead of gutting our health care system? Also, cut the quarter-million-dollar Tory contract with Andersen Consulting, of Enron and WorldCom fame—now masquerading under the new name Accenture, which means nothing—which is wrecking our social system and ODSP. They were bragging about being responsible for, I don't know, 500,000 people off welfare or something like that.

They're really being rough on disabled people and minorities. They have to go through all these message systems, and if they don't understand the language they can be cut off so easily, and they're doing it. It's a heartless crowd at Andersen Consulting. So cut that quarter of a million and let them sue you. Any decent court won't give them a big settlement, because they've been cut across the world. Read the New York Times: All the countries in the world cut Enron and Andersen Consulting.

Cut back the \$15-million school testing program that is a copy of what's happening in the US. There's an excellent article in this amazing book called *Bushwhacked*, which is an exposé of what's happened to the US under the Bush regime. He started all these school testing programs in Texas, and now one third of Texas high school students are leaving the school system because they can't pass these stupid tests. They're doing this in Ontario. If you're a third-level student, you aren't taught first-level math or English. Those third-level kids have to do a first-level test. I marked them for EQAO, and I couldn't believe all these empty books. They said, "Oh, they're third level." That is not at all fair. Those kids have to pass it eventually, and they're going to be forced out of the system. What kind of job are they going to get?

We have to save our health care system, because it's good for Canadian business. Medicare means that Canadian business only has to pay 1% of gross pay for health benefits for their workers. American employers have to pay 8.2%, eight times more, so it makes Canada a much more valuable country to have a company in.

Hopefully, we won't have to follow the Salvadoran people's struggle against their privatization of health care and social security, which took nine months of strikes and citizen mobilizations that successfully stopped the privatization of their system and stopped reprisals against

the strikers. Sadly, people were killed in this, even a child. I read about it in the New York Times.

Let us keep our CPP so we can get some benefits. I could get \$233 from CPP early. That's federal money; it doesn't cost the Ontario Liberals anything. But ODSP takes that \$233 off, and I'm down to \$700. My housing costs are \$700 or more because of condo fees and mortgage—I have a low mortgage. Then with hydro supposedly going open, we're going to be faced with twice the hydro costs, and I haven't paid that bill for two months.

I could rent my basement room with a little two-piece bathroom off it, which is why I bought this condo townhouse. I did, and they took 60% of my rent away. It cost me two ads at \$50 each. Why not just let disabled people keep rent money under, say, \$500? You have expenses: It costs me over \$50 more a month for hydro. And that girl was schizo and threatened to—it was a nightmare. Anyway, the police were very kind and took her away.

Also, if people on workfare could make an extra \$500 a month and keep it, then they would go off workfare, because they would discover they are valuable workers in the system, and they wouldn't have to be lining up on street corners begging for money. Once they get used to making that extra money, they'll work full-time, if they're well.

I'm waiting now for two reattachments of shoulder tendons, which is a serious operation and, because I've waited so long, may be difficult. There's one specialist here, and I have to wait seven months to see him. That's seven more months of extreme pain, especially at night, and I can't stand with my arms down, because it's too much pain on the shoulders.

Increase the \$930 monthly to \$1,200 for the severely disabled—in wheelchairs and that kind of thing. Have a heart, and quit taking all our money away. If the government has to survive on the backs of the severely disadvantaged, then it's not a good scene. This is a Tory regime that I'm complaining about, because I'm sure the Liberals are going to make it just great for us. I would actually go off disability if I didn't know I was going to be stuck for a couple of months with each shoulder and no way of working or making an income.

I feel the best legacy we can leave our grandchildren is not volatile stocks and bonds but our cherished medicare system, which we have to fight to keep. Over the long run for our children and grandchildren, it won't matter what kind of money we leave them if medicare is gutted, because medicare is the most valuable legacy we have for them.

I really want you to read my full dissertation—it's like doing a thesis. If you need any assistant deputy ministers, I'm available. I'm just kidding, but I would actually work for free to help with changes in disability, because it's such an issue, and not just for me. I'm in better shape than most, but I can't believe the horror stories I hear.

Please read this from *Bushwhacked*, this new best-seller that's a big hit. It's one page out of it—I don't

know if it's legal to do that. It outlines the mess in the US system of health care and how it's controlled by privatized scams or schemes or whatever.

Also, I did a dissertation on privatization of hydro whenever that was occurring, and I thought my arguments were great.

OK, hit me.

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The Vice-Chair (Mr Jim Brownell): Thank you very much, Ms Tostevin. I've taken over. I've been asked, as the Vice-Chair, to take the chair. There are three minutes left. It doesn't give us much time. Mr Klees, would you have a quick question?

Mr Klees: I won't ask a question. What I will do is empathize with you, though. You sound in agony over the promises that the Liberals made and didn't keep.

Ms Tostevin: Well, we'll give them time—not much.

Mr Klees: It's been almost four months and, as you say, just to make that one change would have taken them five minutes. Instead, they came up with a bill, this Bill 8—

Ms Tostevin: Well, maybe they never thought about it.

Mr Klees: —that quite frankly is an affront to most people in this province. So I feel for you. Continue to pray for them. They need a great deal of wisdom and a lot of courage.

The Vice-Chair: Mr Ramal? Oh, I'm sorry. Ms Martel. Sorry about that. It was written down incorrectly.

Ms Martel: Thank you for coming here and taking the time to make the presentation, especially when you have a number of your own health care concerns.

I don't think I have a question. I just appreciate your raising the spectre of what happens when you have for-profit health care and some of the concerns we have around that.

Ms Tostevin: It's a disaster.

Ms Martel: For anyone looking at what's happened in the US with their HMOs, with the number of people, the—what is it?—48 million Americans who don't have health care and many others who think they have until they get to a hospital and find out all of the override clauses that make sure they don't have it, it is not a road we want to continue to go down. Health care money should be going into patient care, not into the profits of for-profit providers. So I certainly hope the bill is going to come back amended and that the amended form will have a section that says the government's going to cancel the P3 hospitals and the private MRI and CAT scan clinics. I hope that's what we're going to see when it comes back.

Ms Wynne: Elaine, thank you for coming here today. I just want to say two things. First of all, I do remember you very well from Citizens for Local Democracy, and all the things that you have mentioned today—I mean, you've made a sweeping statement about a whole bunch of—

Ms Tostevin: It's my concern. I didn't write the bill.

Ms Wynne: No, but it's interesting, because there are so many areas where there is so much work to do. In just

about every sector there has been so much damage, and we're trying to put back together this jewel that was Ontario. We've had a very rough eight years. So the second thing I want to say is, I just hope you appreciate that this is a start on one piece, and we're bringing this bill out very early in the process.

Ms Tostevin: I was surprised at that.

Ms Wynne: Exactly. It's coming out after first reading, which is unusual. We're trying to get it right. We're trying to put a framework in place around the council and to close loopholes around privatization issues and around extra-billing and queue-jumping. So we're trying to put some accountability measures in place. There have been a lot of comments over the last couple of days, and there will be more, so there will be amendments that come forward, but it's just a start. On those other issues—

The Vice-Chair: Thank you very much. The time has run out.

ONTARIO ASSOCIATION OF SOCIAL WORKERS, EASTERN BRANCH

The Vice-Chair: Next on the agenda we have Margaret Nelson of the Ontario Association of Social Workers, eastern branch. I don't know if you were here to hear the rules for the presentation. You have a half-hour for your presentation. If you don't use all that time, we will have questions and answers. Welcome, Ms Nelson.

Ms Margaret Nelson: Thank you very much for the opportunity to speak to you today regarding Bill 8, the Commitment to the Future of Medicare Act. I am the past president of the Ontario Association of Social Workers, eastern branch, and chair of the social justice committee of the branch.

The Ontario Association of Social Workers, OASW, a bilingual membership association, was incorporated in 1964. It is one of 11 provincial/territorial associations of social workers belonging to the Canadian Association of Social Workers, which is in turn a member of the 76-nation International Federation of Social Workers. OASW has approximately 3,000 members. The practising members are social workers with university degrees in social work at the doctoral, master's and baccalaureate levels.

OASW has 15 local branches across Ontario. Our association embodies the social work profession's commitment to a civil and equitable society by engaging in social action related to vulnerable, disadvantaged populations and by taking positions on important issues.

I will be speaking to you on behalf of the eastern branch of OASW. Our branch has a membership of approximately 400 social workers, of whom approximately 80% live in Ottawa and the remainder in surrounding communities in eastern Ontario.

Bill 8 is titled Commitment to the Future of Medicare Act. It was introduced in the autumn in fulfillment, as we

understand it, of the Liberal Party's promise to enshrine the Canada Health Act, CHA, in Ontario law, create a health quality council to monitor and provide accountability, and prohibit two-tier health care.

We are disappointed that the bill as it stands does not provide, as promised prior to the recent election, "a fresh injection of the values, commitment and leadership that built medicare." We are concerned that the bill does not further the implementation of the principles of the CHA, does not provide improved democracy, transparency and accountability, and does not prohibit the further erosion of the scope of medicare, the increasing problems of privatization and profit-taking, and two-tiering for those services that have been delisted. Further, we feel it gives the Minister of Health sweeping powers without clear intent or democratic control.

Yesterday in Sudbury, a brief was presented to this panel on behalf of OASW. That presentation set out a vision and called for changes in the bill that would ensure a commitment of the Ontario government to the following:

- (1) Rebuilding the universality, comprehensiveness and accessibility of medicare.
- (2) Prohibiting two-tier medicine and extra-billing.
- (3) Creating a health quality council to report on compliance with the principles of the CHA.
- (4) Prohibiting block fees and charges that create a barrier to access.
- (5) Ensuring public accountability, democratic control and transparency.
- (6) Putting an end to privatization and ensuring democratic public, non-profit delivery of service.

In our presentation, we will address particularly the first of these and the last two; in other words, reinforcing the importance of rebuilding universality, comprehensiveness and accessibility into medicare; ensuring public accountability, democratic control and transparency; and putting an end to privatization in the system. In doing so, I will give examples of situations in Ottawa that limit the ability of government to provide for vulnerable people in need of health care and call for action on the part of the Ontario government to correct these situations.

Universality, comprehensiveness and accessibility—the loss of community care access centre homemaking services:

In April 2002, the Ottawa Community Care Access Centre, OCCAC, announced a decision to eliminate homemaking from its "basket of services." Homemaking had previously been provided to clients who qualified medically and also required personal care. The tasks that were eliminated included basic laundry, shopping and meal preparation, vacuuming, washing floors, dusting, mending, ironing, and cleaning the bathroom. The cuts affected 6,000 CCAC clients in Ottawa.

A study carried out by OASW, eastern branch, soon after the cuts demonstrated the kinds of negative effects that these cuts were having on 62 previously eligible seniors and persons with disabilities. Social workers acted as key informants in this case study. They reported on clients who required homemaking to enable them to

live safely and with some semblance of dignity in their own homes but were unable to receive the service from OCCAC. Clients ranged in age from 31 to 96; 35 were younger than 65 and 27 were seniors. All of them had disabilities or infirmities. The majority were living on low incomes; 39 of the 62 were female and more than half of the 62 were living alone.

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In those early weeks after the cuts, they turned to a number of sources for help: 32% turned to family and 24% to commercial services, for which they or their family would have to pay. Free agency support was available to only 6% of clients, and 8% were able to access partially subsidized services. Friends or volunteers would offer some help to 4%. For 14%, no assistance at all was available. Social workers reported that those clients, and in some cases, their families, experienced frustration and anxiety and various losses.

Extra financial stress and an extra burden of care were placed on families. Social workers reported major concern regarding caregiver burden and inadequate home-making, and saw clients and family members at risk for physical injury or illness as a result. There was particular concern for clients who were subject to falls. A few clients were expected to have to give up living in their own homes prematurely. Effects were seen or predicted for the community, as well, such as more hospital care, more support from social agencies, and more costs as a result of admission to long-term-care facilities.

Other community groups protested the cuts. A meeting in June 2002, hosted by a non-profit organization called Home Care Forum, heard from 70 people who were affected. Major concerns expressed in the focus groups were:

(1) Echoing the findings of the social work study, they described great harm and burden to the clients of CCAC, their families and friends, the support system and the wider community.

(2) The fact that the cuts were made without warning or consultation with the community caused great concern.

(3) The cuts represented a step backward in the philosophy, intention and promise of the CCAC, and government policy, to look for humane and cost-effective ways of dealing with the care needs of constituents.

At a meeting of the city's health, recreation and social services committee in September 2002, Graham Bird, the man appointed by the provincial government to chair the OCCAC, stated that the cuts were temporary and had been necessary in order to shift resources to the 500 people who were on the waiting list for acute care. He reported that, from May to September, the waiting list had been reduced to zero. Some resources could now be shifted back to homemaking, he stated. A year and a half later, no such shift has occurred, and it is clear that the OCCAC does not see restoring homemaking to its basket of services.

At a public meeting held in Ottawa in November, 2003, to explore the availability of homemaking services

for those formerly served by OCCAC, Sandra Golding, executive director of OCCAC, stated that under Bill 130, the Community Care Access Corporations Act of 2001, all CCACs were required to carry out their mandate in a consistent manner. Thus, those centres that had provided homemaking services were no longer permitted to do so, except under very strict criteria. These criteria permit a CCAC worker who is in the home to assist a client with a shower only to clean the tub used for the shower or water spilled on the floor that might create a safety hazard. Laundry can be done only for an incontinent client. Even if the worker has free time while carrying out authorized duties, he or she is prohibited from using that time to carry out any other homemaking task needed by the client.

Community response to the cuts resulted in funding from the city and from the province to enable community non-profit organizations to increase homemaking services to serve the most needy. Home Help, a city service, provides homemaking free, but only to people whose income is extremely low. This is how low: Those receiving social assistance or single people with an income no greater than \$3,000 a year, or a couple with an income of no more than \$5,500 a year. I can't imagine where they live. Non-profit organizations in the community, such as seniors' centres and resource centres, are able to provide homemaking for a fee of \$10 to \$12 an hour. Thus, there are some services for some people. It is not known how many people do not receive such services because they are not poor enough to obtain them free but cannot afford to pay even the rate charged for non-profit services.

What I have described is just one example of how a service that was universal has been downloaded onto the community and families. No longer is homemaking a right for people medically qualified for it. This change in policy on the part of the former provincial government was a step in the wrong direction, a step backward from the stated goal of this government to ensure that "Ontarians can receive better care at home." It ignores the findings of recent studies in British Columbia that point to homemaking, in particular, as a service that saves money in the health care system, even in the short term. I would refer you to Marcus Hollander's study *Unfinished Business: The Case for Chronic Home Care Services, a Policy Paper*.

Homemaking services are not a frill; they are necessary to enable medically qualified seniors and persons with disabilities to live safely and with dignity in their own homes. They are cost-effective services, saving costs in the acute care and long-term-care systems. We are encouraged by the promise made by Premier McGuinty prior to the election: "We will invest in home care so that Ontarians can receive better care at home." Again, "Our first step is to get our vulnerable and elderly the services they need."

We look to Bill 8 to provide a clear commitment to restoring universal access to medically necessary services such as homemaking.

Ensuring public accountability, democratic control and transparency—the loss of community boards for CCACs:

A second important concern related to the CCACs is the loss of community boards. The Community Care Access Corporations Act, 2001, gave the government the power to appoint both the boards and the chief executive officers of Ontario's 43 community care access centres. The resulting imposition of centralized control over the Ottawa CCAC was strongly resisted in Ottawa at the time and has led to a lack of open communication between the OCCAC and the community and a lack of trust in the OCCAC. The right to a publicly elected community board must be reinstated for the OCCAC. This government has promised a more democratic Ontario. We call for a revised Bill 8 to ensure a commitment to accountability that is coupled with democratic control of public services.

Putting an end to privatization and ensuring democratic public, non-profit delivery of service—the case of the P3 hospital for the ROH:

Prior to the election, Premier McGuinty promised to cancel the P3 deal for the Royal Ottawa Hospital, ROH. The changes in the deal announced in November 2003 do not significantly alter it. The principle remains the same: The proposed P3 deal will introduce the profit motive, conflicting with the hospital's goal of providing a public service. The building will be paid for with a 20-year mortgage, with the mortgage payments coming out of the operating budget of the hospital. This method of funding threatens the ability of the hospital to maintain the volume and quality of services that the community will require over the next 20 years. Further, although the proposed hospital is to serve the whole of eastern Ontario, it will have 19 fewer beds than the present hospital. It is also expected that the focus of the hospital will shift from patient care to research. With fewer beds and a changed emphasis in the hospital's role, what provision will be made to provide service for patients no longer being served at the ROH? What will the costs be for providing those services elsewhere in the community?

There is convincing evidence, based on the experience in Great Britain and elsewhere in the world, that public-private hospital arrangements are more expensive and less satisfactory than those built in the conventional way, with capital funding raised by government. Costs with public-private consortia are higher, fewer beds are provided and, in some cases, the hospitals designed privately are not conducive to good patient care. The imposition of two separate sets of management under the same roof, one with the goal of providing a public service, the other with the goal of maximizing profit and growth, has been found to be fraught with problems. Ultimately, the taxpayer loses and so do patients. I would refer you to a report in the British Medical Association Journal, 2002, on "Private Finance and 'Value for Money' in NHS Hospitals: A Policy in Search of a Rationale?"

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Part of the P3 deal for the ROH includes what we understand to be a 66-year contract for so-called non-clinical services. These are medically necessary services

that may include provision of food, laundry, cleaning and maintenance, record-keeping, lab tests and diagnostics. These are services that support patients' daily living. They are essential to infection control, nutrition, diagnosis and recovery. In a public health care system such as ours, they should be provided on a non-profit basis.

Lack of openness and transparency is a characteristic of public-private partnerships. This is already clearly evident in the nature of communication regarding the deal for the new building at the ROH. Instead of being the open, democratic process this government has promised, the deal is still cloaked in a veil of commercial secrecy such that the plan of the building and the exact nature of the contract being considered are not known to the public.

If the hospital in Ottawa is built according to the public-private arrangement that is now planned, there's a very strong likelihood that six other hospitals slated for construction elsewhere in the province will be built under similar conditions, thus firmly establishing private, for-profit financing as the preferred method of building hospital facilities by this government.

The issue of the P3 hospital for the ROH is a particularly critical one not only for the reasons discussed above but also because it provides, for the taxpayers of Ottawa and the province, a litmus test that will indicate how committed this government is to its pre-election promises such as this one: "We will end the Harris-Eves agenda of creeping privatization."

We maintain that there is no place for P3 hospitals in a public health care system. They skim off millions of dollars of public funds, funnelling that money into the hands of private, for-profit corporations. They threaten the sustainability of medicare. If this government is serious about its commitment to the future of medicare, it will amend Bill 8 to ensure that all privatization, including P3 hospitals, is indeed ended in the Ontario health care system.

The Vice-Chair: Thank you very much, Ms Nelson. We have 12 minutes left. We'll start with Ms Martel.

Ms Martel: Thank you very much, Ms Nelson, for taking the time to be here today. You're right: One of your colleagues was in Sudbury yesterday. We appreciate that social workers, as a group, are taking some interest in this bill.

I want to focus on privatization because it seems to me that if the preamble was to have any effect at all, a preamble which talks in glowing terms about public care and public administration and medicare, then the rest of the details of the bill would support that. There is nothing in the rest of the bill that supports any of that, regrettably. Maybe the government intends to do that at some other time, except that if these things were a priority for them, I would think that they would be coming forward in this bill that purports to be supportive of medicare, to promote medicare and enhance medicare.

I worry about the P3 hospitals because we haven't seen the arrangements that are being done behind our backs, both here in Ottawa and in Brampton. At the point that we will see them, which the government has said is

when they are essentially signed, it will be a little late to do much about it, won't it?

Ms Nelson: Yes.

Ms Martel: The government might tell you that no decisions have been made with respect to other hospital renewals, except that we heard an interesting presentation yesterday from Michael Hurley, who leads the Ontario Council of Hospital Unions, who reported to the committee yesterday that in a meeting they had that he was part of, with the OHA, the Ontario Hospital Association, before Christmas, the OHA made it very clear that they were in discussions with the Ministry of Health with respect to either six or seven other hospitals that have to be reconstructed, and the government was certainly looking at a private financing model. The OHA was very up front with Mr Hurley and others who were at their meeting about that.

I think there is no doubt that's where we're heading. If I had any doubt about that and if I thought the government was doing something differently, it would have come with the November announcement, which should have been, "We're cancelling these deals, and the public sector is going to finance hospitals." That's not where we're heading. So it will not be surprising to me in the least to see that reconstruction of hospitals that flow after William Osler and Royal Ottawa will in fact use a P3 model as well and private financing, which will cost all of us a whole lot more.

I appreciated the very specific references in terms of what to do that you made with respect to the CCAC. Correct me if I'm wrong: Is the CCAC here being taken to court now with respect to the homemaking issue?

Ms Nelson: There is a court case at the moment, yes.

Ms Martel: I think that was to start in the new year on behalf of a very specific client, but obviously if the case can be won, it should have impact on the rest of those who lost their homemaking services.

Ms Nelson: It's on today, actually.

Ms Martel: I will watch that with some interest, because I certainly was given some advance notice that this was going to go forward, and I hope they are successful. It would have been my preference that this government would end competitive bidding in home care, and that might deal with some of the problems we're having if the government invests more, as they promised.

In terms of what you see with the CCAC, you made it very clear that the board again should be democratically elected—I agree with that for obvious reasons—and that there has to be a major change in terms of dealing with clients' needs. Was there any further follow-up after the follow-up that was done by social workers in June 2000? Was there follow-up done again with these particular clients to see where they have ended up? Have they ended up in long-term-care facilities, a consequence of not receiving this, or did you go back and do that?

The Vice-Chair: This will have to be very short. We're running out of time.

Ms Nelson: There is a study that's underway. It should have been completed, actually, by the OCCAC, but we are looking for the report on that. It was to have

come out. I believe it was to have been ended in November; we were to have heard in December, but still not. So what that will show, I don't know. We weren't entirely confident in the terms of reference of that.

Mr Levac: I'll pass it over to Ms Wynne for a moment. I'm just going to make an observation.

Thank you, Ms Nelson, for your presentation and the work that your group and all social workers do in our province. Obviously, the work is not just confined to health care. It's education and long-term care and senior citizens and everything else. By way of why I'm concerned about that is that recently in my riding there were some concerns about elder abuse and stuff, and we're applying to receive permission to proceed with the social worker who will act as a complete advocate for our senior citizens, unconnected to the agency. So obviously I have a vested interest in ensuring that your words are heard. I will make sure that those words are passed on.

My final observation is one for this committee and for the people who are listening. Just as a caution, everybody wants to put words in everybody else's mouth. That's the bottom line. What's happening is that some people have a duty to say we're wrong; some people have a duty to say we're right. We're going to have a duty to say we're right and we're trying to accommodate things. The bottom line that I'm aware of is, as my committee work over the years has indicated, that this is the place where we probably get the best ideas and the best opportunities because it comes from the people who are providing the services. So take heed that your words are heard, your words will be dealt with, and people will continue to move forward, as we have tried to do in all our committee works. But we have to remove the cloud and smoke of people who are trying to tell us what our thoughts are and what are actions are.

My last comment is to the committee, although I'm leaving the committee; I was subbed in. I want to take a moment to thank the people in the background, obviously, as they continue to work. They've put this thing in place so that the public can come forward and present to us. So to the translators, to the audio people, the clerk's office and everybody else, thank you so much for the diligence that you put into this work. Thanks to the committee members for going around Ontario and hearing the voice of the public.

The Vice-Chair: Ms Wynne, about two minutes.

Ms Wynne: Just a couple of quick points, and thank you very much for your presentation.

I just wanted to reaffirm the issue around the hospitals where decisions have not been made, the six or seven hospitals that are being discussed at this point. There has been no decision made on exactly what the framework will be except that we're committed to public ownership, public accountability and public control. So whatever we're doing going forward, those are the principles that we're operating under. I just wanted to reaffirm that.

I don't know if you had a chance to see Minister Smitherman's remarks from the beginning of the hearings—I'll give you a copy of those—because we're

acknowledging that there are a lot of changes that need to be made to this bill.

There are two things I wanted to say. First of all on the home care issue, which is of huge concern to all of us: The reason home care is mentioned at the beginning of this bill is that this is the future of medicare act. So what we're trying to do is put a framework in place that will deal with all the issues that we're going to have to deal with coming forward. We know there are changes that have to be made. They're not all being made in this bill.

My last point: I wanted to ask you, in terms of monitoring privatization, do you have any specific suggestions? You talked about privatization in a number of contexts in your presentation. Do you have a specific suggestion about how we might do that? This is a bill that is set up to put a framework of accountability in place. So if we were to monitor privatization, how would you think we would do that? You can think about it too, and you can let us know, but I think it's an interesting question.

The Vice-Chair: That might be the case here for the simple reason that we've run out of time.

Ms Wynne: OK. If you have any comments, I'd love to hear them.

The Vice-Chair: If you could get back to us.

Next we'll move on to Mr Klees.

Mr Klees: Thank you very much. I appreciate your presentation. The work of social workers around the province is certainly appreciated by all. I will be very interested to see how much substance there is to Mr Levac's comment about how effective the work of the committee is in actually incorporating the many good recommendations that came forward to this committee.

We have had numerous representations from well-meaning people, front-line people who effectively are saying that the best part of this bill is the preamble, which sets out all of those objectives that very few Ontarians are going to take exception to. However, everything past that seems to be smoke and mirrors, and worse than that, can be very detrimental to the delivery of health care services in this province. So the recommendation really has been to scrap anything after the preamble and get back to work putting a bill together that's based on the good recommendations that have come forward from people like you. That will be the real task of this committee. I ask you to stay tuned to see how much of your good advice ultimately will be incorporated into the work of this committee. Thank you again for joining us, and for the good work that you do.

Ms Nelson: Thank you. We certainly will be watching to see what the outcome is of the hearings.

The Vice-Chair: Thank you very much, Ms Nelson.

That brings us to the end of our deliberations here in Ottawa. I would like to thank the citizens, the stakeholders, those who work in health care, those who have made presentations here today. I would like to thank the committee for your focus and for your good work here, and also the staff who work so hard to bring this all together. It's very important.

We now stand adjourned to Windsor.

The committee adjourned at 1644.

STANDING COMMITTEE ON JUSTICE AND SOCIAL POLICY

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Legislative Assembly of Ontario

First Session, 38th Parliament

Official Report of Debates (Hansard)

Thursday 19 February 2004

Standing committee on
justice and social policy

Commitment to the Future
of Medicare Act, 2003

Chair: Kevin Daniel Flynn
Clerk: Susan Sourial

Assemblée législative de l'Ontario

Première session, 38^e législature

Journal des débats (Hansard)

Jeudi 19 février 2004

Comité permanent de la
justice et des affaires sociales

Loi de 2003 sur l'engagement
d'assurer l'avenir
de l'assurance-santé



Président : Kevin Daniel Flynn
Greffière : Susan Sourial

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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON
JUSTICE AND SOCIAL POLICY

Thursday 19 February 2004

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

COMITÉ PERMANENT DE LA JUSTICE
ET DES AFFAIRES SOCIALES

Jeudi 19 février 2004

The committee met at 0904 in the Windsor Hilton Hotel, Windsor.

COMMITMENT TO THE FUTURE
OF MEDICARE ACT, 2003LOI DE 2003 SUR L'ENGAGEMENT
D'ASSURER L'AVENIR
DE L'ASSURANCE-SANTÉ

Consideration of Bill 8, An Act to establish the Ontario Health Quality Council, to enact new legislation concerning health service accessibility and repeal the Health Care Accessibility Act, to provide for accountability in the health service sector, and to amend the Health Insurance Act / Projet de loi 8, Loi créant le Conseil ontarien de la qualité des services de santé, édictant une nouvelle loi relative à l'accessibilité aux services de santé et abrogeant la Loi sur l'accessibilité aux services de santé, prévoyant l'imputabilité du secteur des services de santé et modifiant la Loi sur l'assurance-santé.

The Chair (Mr Kevin Daniel Flynn): We'll call the meeting to order, ladies and gentlemen. It's a little bit after 9 o'clock, and we should get going.

Welcome to those who have joined the committee. Mr Hudak, Ms Di Cocco, thanks for joining us here.

WINDSOR REGIONAL HOSPITAL

The Chair: Our first presenter this morning is Mr David Musyj, vice-president of corporate services and medical affairs for Windsor Regional Hospital. You've got 30 minutes to make your presentation. You can use that any way you choose. At the end of your presentation, we'll divide the remaining time evenly among the three parties to ask you any questions about your presentation. The floor is yours.

Mr David Musyj: Thank you, and good morning, everybody. My name is David Musyj. The last name is spelt m-u-s-y-j. I'm the vice-president of corporate services and medical affairs at Windsor Regional Hospital, as well as acting in the capacity of its general counsel.

I want to thank the members of the standing committee on justice and social policy for allowing me to make a verbal presentation on Bill 8 today. I'll be addressing two issues identified in Bill 8: the account-

ability agreements, found in part III of the bill, and physician compensation, found in part II of the bill.

I am somewhat buoyed by the comments of the minister before this very committee on February 16, 2004. However, a dear friend of mine likes to say, "The proof of the pudding is in the eating." I will await the actual amendments.

I can inform you that Windsor Regional Hospital supports and embraces the concept of accountability. The hospital is an active participant in the hospital report series. In addition, over the past two years Windsor Regional Hospital has been involved in the third party review and in an operational review, along with Hôtel-Dieu Grace Hospital, Windsor, which, once it was published, resulted in the appointment of a monitor for both hospitals.

This commitment to accountability has resulted in the creation of the Windsor Hospitals Coordinating Committee between the two hospitals, and the joint appointment of a chief financial officer and an integrated vice-president of clinical services between the two hospitals.

However, the implementation of accountability needs to be done in a proper context, with proper entities and with a mutual understanding and agreement between the parties. Otherwise, one could end up creating accountability objectives that cannot be achieved right from the outset. This is as a result of either the party requesting the objectives not having the authority or ability to ultimately ensure the objectives were achieved, or the party required to achieve the objectives knowing immediately that the objectives are unachievable but not having a say in their creation. Both of these are as a result of the objectives being imposed unilaterally.

Bill 8 states that the minister can require a health service provider or any other prescribed person to enter into an accountability agreement. This possible unilateral implementation will not work and will not achieve what the minister wants, which is accountability.

In order for these accountability agreements to work and achieve the objectives of the minister, he will need to ensure that the corporate entity/person he is creating an accountability for has a voice in creating the agreement and setting the objectives. Both parties need to be clear on what the objectives are, how they will be measured and what result is required to achieve them.

You don't have to look far in order to see how this can be done, and done well. Effective January 1, 2004, the

cancer centres across the province integrated their operations with their host hospitals, Windsor Regional Hospital being one of these. They did so freely by negotiating a cancer program integration agreement, which I will refer to as the CPIA. The parties to the agreement were Cancer Care Ontario and the particular host hospital.

The CPIA states at article 12 that "in order to support the principle of accountability this agreement identifies mechanisms for the hospital to demonstrate performance within the context of a provincial plan." The CPIA then provides that the parties will mutually set volume and quality expectation targets. If a variance occurs between the targets and the actuals, then the parties meet to discuss the variance and the reason for the variance. The parties decide if changes to the targets need to be made. Only then do possible changes occur to funding, program content etc.

As stated previously, the CPIA has been negotiated between the two corporate entities, not the presidents and CEOs of the hospital and Cancer Care Ontario. However, the hospital, for example, then places the burden on its president and CEO to ensure the hospital's operations support the achievement of the CPIA and requires the president and CEO to keep the board apprised of the process. Again, the accountability flows between the hospital and its president and CEO.

The CPIA does not create an ability for Cancer Care Ontario to implement changes to the employment agreement of the hospital's president and CEO. Such a move would violate almost every principle of corporate law regarding the relationship between a corporation, its board of directors and its president and CEO, increasing the likelihood of chaos in a corporate governance process and the creation of a lame-duck board of directors.

0910

This leads me to my last point on this topic. The ability of the minister to unilaterally change terms and conditions of an employment agreement, or any agreement for that matter, as a result of the failure to meet an accountability agreement is not correct. For the reasons outlined above, this is not a workable solution. This would interfere with the proper operation of a corporate entity and again, as I stated, create a lame-duck board of directors.

An alternative to such a power would be a requirement that when creating an accountability agreement the minister attempt to negotiate a provision with the hospital corporation that it must negotiate a clause with its president and CEO that provides some consequences for the achievement, or non-achievement, of these objectives. However, a decision on what form that could take should be left to the body that has the corporate and legal ability to make such a decision: the employer of the president and CEO, the hospital's board of directors.

I can only emphasize the risks cited in the British Columbia Auditor General's 2003 Report on Performance Agreements: "One is that the boards can be bypassed in strategic decision-making, becoming advisory boards rather than governing boards. Another is that the

CEO will receive conflicting messages. A third risk is that the CEO will view his or her job as that of managing the board on behalf of the ministry, rather than reporting to the board."

I will now deal with the issue of physician compensation, found in part II of the bill. Windsor Regional Hospital fully supports the concept that physicians should not receive monies in excess of the OHIP fee schedule for the provision of insured services. Windsor Regional Hospital, similar to many other hospitals in the province, did provide payments, ie stipends, to physicians in excess of the fee-for-service billings they were receiving from OHIP.

I can inform you that over the past few years, Windsor Regional Hospital has gradually eliminated these excess payments. In return, in some cases, Windsor Regional Hospital has created what it calls internal AFAs, or alternative funding agreements. The basic tenet of these AFAs is that physicians must assign their OHIP billings directly to the hospital. In return, the physician receives a fixed amount of monies from the hospital. In addition, these internal AFAs require the accountability Bill 8 desires.

Bill 8, as written, would prohibit these internal AFAs. Since they are not approved by the ministry, they would violate section 8 of the bill. In addition, I can inform you that the AFAs approved by the ministry do not contain the accountability that Windsor Regional Hospital's AFAs contain. With all due respect, all the ministry's AFAs do is create a funding mechanism for the assignment of OHIP billings and the payment for physicians.

You are now probably asking, what is so unique about WRH's internal AFAs? Well, they provide for accountability by including, among other things, the following terms:

(1) Specific hours that the physician needs to be present to attend to patient care. Thus, nursing staff and other resources can be coordinated to ensure that the complete medical team is present for the patient's benefit—no need to try to find someone;

(2) A requirement that physicians attend regular staff/management meetings to discuss issues that enhance patient care and administrative functioning of the hospital;

(3) A requirement that physicians are directly involved in, and sometimes lead, ongoing staff and patient education;

(4) A requirement that physicians are cognizant and directly involved in addressing patient satisfaction results and resource utilization;

(5) A requirement that the physicians' performance is reviewed by the hospital on a regular basis.

The internal AFAs at Windsor Regional Hospital have been very successful. They are a great physician recruitment and retention tool.

I can inform you that the hospital has attempted to pursue ministry AFAs for some of its physician groups. However, the ministry only approves a fixed amount per year and there is a waiting list of some 70 applications.

I strongly urge that unless the legislation is changed to permit internal non-ministry-approved AFAs, a process needs to be developed to fast-track approvals for these internal AFAs and allow for a grace period while awaiting processing. However, as previously stated, if the existing ministry AFAs are used, I do not believe the minister will get what he desires, which is accountability.

Those are my submissions. Thank you for your time.

The Chair: Thank you, Mr Musyj. It's about 9:16, so you've used up about 12 minutes. That's left us with 18. Let's start with the PCs. You've got six minutes for questions.

Mr Frank Klees (Oak Ridges): Thank you very much for your presentation this morning. You've addressed a couple of key issues that we've heard repeated a number of times, and you reaffirmed the concern around the issue of accountability. I'd like to deal with that first of all.

The minister admitted in his opening remarks to this committee that he was clearly embarrassed by the flaws in this bill. You've probably read his statement. You've heard that he is prepared to make wholesale changes to this bill. Some of those changes he has undertaken to address the very issues you're referring to. The question really remains as to whether we can rely on his commitment to that. This government has quite a track record of not doing what it said it was going to do, so why we would believe that promise remains to be seen.

Nevertheless, the accountability issue in this bill goes one way only; and that is, what you and your institution can do for the government. There is no reference whatsoever to accountability on the part of the Ministry of Health. I don't know about you, but I've been involved in many circumstances where I've been called to help advocate on behalf of hospitals in my area, where the Ministry of Health has been dragging their feet, where they haven't come forward in a timely way with approvals, sign-offs, if you will, on budgets and so on.

I'd be interested, first of all, in your comment on the issue of the lack of accountability mechanisms here that speak to what the ministry must do and how they can be brought into compliance. Lots is said about what the minister will do to you if you're not complying. Second, do you have some recommendations in terms of how we can build some of that accountability into this process coming from the government to you?

Mr Musyj: As I stated in my presentation, that's the importance of making sure that these accountability agreements are freely negotiated. As I stated, you don't have to look far to see one that is starting to work, and that is the one between Cancer Care Ontario and host hospitals in the province. Dr Alan Hudson, on behalf of Cancer Care Ontario, is the one who pursued this way of integrating cancer centres and their host hospitals, which took effect January 1. Those freely negotiated agreements do have accountabilities cutting across both ways. What we would see is a similar process in developing the accountability agreements that the minister talks about. They would be negotiated between the ministry, the

minister and the hospital, and it would be up to the hospital itself, if it achieves certain objectives, to make sure that there are certain commitments made by the ministry in setting those objectives. That's the process we would see taking place to ensure that occurs and that accountabilities flow both ways.

Mr Klees: What about the numerous references in this bill—let's say you did enter into a negotiation and the minister was gratuitous enough to say, "I'll agree that we'll negotiate these things," but the bill refers to the fact that you will be deemed to have agreed to whatever the minister decides. He may call you in and have a nice sit-down and talk about what we should do and negotiate—you might negotiate for six months—but at the end of the day the bill says that whatever the minister says, you will be deemed to have agreed to it. How do you feel about that?

Mr Musyj: That's the point: It needs to be freely negotiated. But there are certain provisions in the Public Hospitals Act currently that give the minister certain other powers. If he or she feels that a hospital is not living up to its obligations in how it is being run, he or she has the ability to appoint inspectors, supervisors etc. So I guess ultimately they already have that power with the final say in things. If they feel that the hospital is being unreasonable in its negotiations of these accountability agreements, they could fall back to what is currently existing in the Public Hospitals Act.

Mr Klees: With one exception, though: The current legislation makes it very clear that whatever decision is made by the minister must be made in the public interest. There is no reference to the public interest anywhere in this legislation. Does that concern you?

Mr Musyj: It would concern us if we entered into good-faith negotiations and continued in negotiation and then something was imposed unilaterally, like you said, that wasn't in the public interest. If that hypothetical occurred, we'd be very concerned.

0920

Mr Klees: I have another question regarding AFAs. How many AFA agreements would you have in your hospital?

Mr Musyj: We have approximately four now. The four of them combined probably cover at least 40 to 50 physicians.

The Chair: Mr Klees, your time has expired.

Ms Shelley Martel (Nickel Belt): Thank you very much for being here this morning. We've been questioning why the minister wants to move with the kind of power that he does through the accountability agreements. There certainly has been the suggestion that if the minister has a concern about what's happening in a hospital now, he can use the Public Hospitals Act in the public interest. He can have an operational review, a capital review, a supervisor, the whole nine yards. Some of our communities have experienced that, and mine is one.

Despite what the minister said earlier this week, we haven't seen the changes yet. There have to be wholesale

changes to this whole section before it might be something people could agree on. There is certainly the reference you made to accountability agreements in your concerns, but there are some others in this section that have really serious, draconian powers given to the minister, and none of us can figure out why that would be done.

For example, over and above the accountability agreements are the compliance directives. Section 22 says:

"(1) The minister may at any time issue a directive compelling a health resource provider or any other prescribed person, agency or entity to take or to refrain from taking any action that is specified in the directive or to comply with one or more of the prescribed compliance measures." That's pretty broad.

"(2) In any directive under this section, the minister may specify the time or times when or the period or periods of time within which the health resource provider or any other prescribed person, agency or entity to whom the directive is issued must comply with the directive."

The termination section:

"24. The minister may at any time terminate an accountability agreement or a compliance directive, and may at any time vary a compliance directive or issue a new compliance directive."

This is the best one:

"Consequences of failure"

"26. Where, in the opinion of the minister, any person, agency or entity described in section 21 or 22 fails to enter into an accountability agreement, fails to comply with any terms of any accountability agreement or fails to comply with all or any part of a compliance directive, the minister may make an order providing for one or more prescribed measures."

These are broad, sweeping, draconian powers, far beyond what's in the Public Hospitals Act now, allegedly in the public interest. Do you have any idea why the minister might want to have such broad, sweeping, draconian powers? Has your hospital or other hospitals done something to merit this kind of power on the part of the minister now?

Mr Musyj: As I stated, our hospital has been subject to an operational review with the other Windsor hospital. It did not result in the appointment of an inspector or a supervisor. Actually, it resulted in the appointment of a mutually agreeable monitor. The monitor's role is to work with the parties and monitor their progress over restructuring. As of now, we're hopeful. We've been through that process very recently and those were the steps that were taken previously and are still in place under the new government. So we hope that we've done nothing to merit those types of sweeping measures.

Ms Martel: You hope this is it.

Mr Musyj: Yes, that's the point we made. We've done a lot up to this point. We're hopeful that we're on the right track and don't have to meet with something further.

Ms Martel: If you look at the last number of years, where either a supervisor was put in place or an oper-

ational review was instituted, in terms of the overall number of hospitals that exist in the province, the numbers were relatively small. I think in only one case was a board removed. So I don't see what the problem is to merit such broad, sweeping, draconian powers. As you say, the proof will be in the pudding, because we haven't seen the changes yet either.

Let me ask just a couple of questions about the AFAs. You certainly intimated that your internal agreements are far superior to the government's. I assume that has to do with the accountability mechanisms, perhaps, which aren't included in the government's. Is that correct?

Mr Musyj: That's the focus. Any of the government's AFAs, from what we've seen and dealt with, clearly have an assignment of OHIP billings in return for a flat fee. What we've put in place in our agreements with our physicians—and again, mutually agreed upon and negotiated with the physicians—are some of the accountabilities I outlined previously. If accountabilities are what you're looking for, our concern is that if this legislation is passed as it is worded on those types of agreements, we would be in violation of the act at that point with these internal AFAs. We would have to stop them, and that would be a grave injustice to the hospital, to the physicians and most importantly to the patients, because our patient satisfaction scores in those areas in which they are in place have gone up.

Physician retention and recruitment has been very solid in those areas. Staff are happier in those areas because the physicians' agreements—and they sign on to them individually and collectively in groups—state that they have to be involved in patient education, they have to be involved in staff education. That's something they don't get paid for through OHIP, but they've agreed, as a part of these internal AFAs, to be a part of that. So we find them very positive, and we want them to continue. We want to find a way for them to continue without being thrown out automatically.

Ms Martel: In fact, it could be a model which the ministry could use if they really wanted to enhance accountability.

Mr Musyj: Yes. It's something to build on, definitely.

Ms Martel: One final question: If nothing changes and under law you are in effect out of compliance, what's going to happen to your recruitment and retention efforts?

Mr Musyj: I would expect the physicians who are part of it would go back to their OHIP fee schedule and be subject to volume variations etc, and we could face difficulties with respect to retaining physicians. Again, they are attracted by these AFAs, they like them, and the ones who have signed have stayed. Before we put them in place, we had problems with retention and recruitment in these areas. That's one of the reasons we put them in place. Some have been around for over a year. We haven't had any physicians leave who are party to them.

The Chair: Ms Smith.

Ms Monique Smith (Nipissing): Thank you, Mr Musyj. We're very happy to have you here today. As you're aware, this government has taken forward Bill 8

after first reading, and it was anticipated that we would be placing amendments to this act after we had our consultation with Ontarians. We are certainly happy that you're here today to give us your input in order that we might improve this legislation.

I'm sure you're aware through your position at the hospital that we've been in discussions with the OHA, the OMA and other stakeholders about various amendments to this legislation, and I hope your association has assured you of some of the language and work that we've been doing over the last few weeks.

As well, you referenced in your introduction that you had seen or at least heard the minister's statement—and if you haven't got a full copy, I'm happy to give you one today—where he outlined some of the changes. One of the most important changes that we are proposing is establishing that the accountability agreements will be between the boards of the hospitals and the ministry, which I think will calm some of your fears about the interference between boards and the CEOs of the hospitals. Certainly we don't intend to affect governance of hospitals in any way. We expect that after accountability agreements are come to between the hospital boards and the ministry, a board would then follow with a performance agreement between its CEO and the board. Is that your understanding? Have you heard that those discussions have been taking place?

Mr Musyj: I've heard they've taken place. The OHA has informed us as late as yesterday that they want to see the amendments as well before they go one way or the other with respect to their support. So they're anticipating or waiting for the amendments, and so are we. So again, as I've stated, the proof of the pudding is in the eating, and we'll see what they said.

I guess ultimately what we're concerned about as well is that there can't also be this final hammer still hanging out there over the presidents and CEOs. That has to be off the table in the sense that if the ministry or the minister enters into an accountability agreement with the hospital, as a part of that they could ask that this be folded into the president's and CEO's employment agreements. But if they don't and they can't negotiate it and it doesn't happen, then that's as far as it goes. There can't be this hammer in the legislation sitting out there saying, "But ultimately we still have the power to do it if the board does not agree to do it." Again, that would create this uncertainty in the corporation.

0930

Ms Smith: Do you agree, generally speaking, with the notion of accountability agreements between the boards and the ministry?

Mr Musyj: Certainly. As I stated, our hospital has gone through hospital report series, third party reviews and operational reviews, and has a monitor in place who's down basically on a monthly if not a weekly basis with our hospital. So we definitely support accountability, but again, it's got to be a two-way street.

Ms Smith: Right. And the monitor you talk about and the interaction you've had with the ministry is as a result of section 9 of the Public Hospitals Act, correct?

Mr Musyj: Arguably, no. There's no such concept in the Public Hospitals Act, this monitor concept. It had to be mutually agreed upon by the parties at the time, and that was clear. The hospital had to sign on the dotted line that it agreed to the appointment of the monitor. But in the legislation of the Public Hospitals Act, if you don't agree to the monitor, the next step probably is a supervisor; although that wasn't threatened, one is led to believe that could possibly occur. In this process, the terms of reference of the monitor and the appointment of the monitor were really freely negotiated between the previous government and the hospitals, and it was up to hospitals to sign off.

Ms Smith: OK. And certainly there's been a lot of work done in this area between your two hospitals. We appreciate that. I have been at a number of meetings where the minister has used Windsor as an example of co-operation and a really good system that seems to be working very well for the community, so we commend you for that.

Mr Musyj: I appreciate that.

Ms Smith: We're looking at possible amendments to the legislation that would allow for a whole process for the implementation of the accountability agreements, and a process as well for directives and orders if there's non-compliance. I was interested, when you were talking about your CPIA, if you could just give me a quick rundown of the process in place for the negotiation of that. Also, if you're unable to reach an agreement, what provisions are there to put an agreement in place?

Mr Musyj: With the CPIA, what happened is that last year the host hospitals and Cancer Care Ontario struck committees to negotiate this cancer program integration agreement. Again, it was freely negotiated amongst the parties and it put in place certain accountabilities, because that was one of the big issues in that agreement too. When the services integrated, Cancer Care Ontario wanted to ensure, when the monies got flowed directly to the hospitals from that point on to operate the cancer centres across the province, that there were certain accountabilities with respect to volumes, with respect to quality etc. So those are outlined; there's a structure for the parties to negotiate what the volumes are, what the quality expectations are. In return, the hospitals were guaranteed that they were going to be provided these monies and these services and this equipment etc, those types of things coming from Cancer Care Ontario.

If those targets are not met—targets have been set by the parties, mutually agreeable targets that are reasonable and rational—the agreement calls for the parties to get back together to look at why the targets were not met. They could be things that are out of the parties' control; for instance, unfortunately we had SARS. Something like that changes everything: Across the province, volumes go down, people don't go to hospitals. That could affect a lot of things. So if something like that occurs, you sit down and discuss it before changes are made, if changes need to be made. It's a freely negotiated, ongoing negotiated, dynamic process.

Ms Smith: Mr Chair, on a point of order: I'd just like to inform my colleagues on the other side, who I know are waiting for the framework on amendments, that we should have that by 1 o'clock this afternoon. I just wanted to assure them that that was on its way.

The Chair: Very good.

Thank you, Mr Musyj, for coming today. We appreciate it.

HEPATITIS C NETWORK OF WINDSOR AND ESSEX COUNTY

The Chair: I now call forward Susan Price, Michelle Graham and Andrea Monkman from the Hepatitis C Network of Windsor and Essex county. Make yourselves comfortable. The same rules apply to you as to the previous delegation: You've got 30 minutes to use any way you see fit; at the end of your presentation, we'll split that time up equally amongst the three parties. This time the questioning will start with the NDP and Ms Martel. Would you each identify yourselves for Hansard, please.

Ms Susan Price: My name is Susan Price. I am chairperson of the Hepatitis C Network of Windsor and Essex county.

Ms Michelle Graham: I'm Michelle Graham. I'm the secretary for the Hepatitis C Network of Windsor and Essex county.

Ms Andrea Monkman: My name is Andrea Monkman, and I am peer support person and co-founder of the Hepatitis C Network of Windsor and Essex county.

Ms Price: I will be delivering our presentation, and Michelle and Andrea are here to help answer any questions.

We'd very much like to thank all of you for coming to Windsor. We would also very much like to thank you for the opportunity to appear before you today. The Hepatitis C Network is very pleased to be a part of this process that attempts to meet Ontario's needs and strive toward accessibility and accountability in health.

Overall, right up front you should know that we're supportive of this government's initiative. We do, however, have some questions and some concerns. Before we get to them, I would like to introduce you to the Hepatitis C Network and give you an overview of the disease and the context in which hepatitis C has unfolded in Ontario, including the government's response to hepatitis C. I'd then like to highlight some of our kudos and concerns regarding Bill 8, including those qualities we feel are important to people affected by hepatitis C.

Because, for the past 15 years or so, they have been listening to and negotiating their welfare with various levels of government, we feel that people affected by hepatitis C are uniquely situated to contribute to any discussion related to the government's role in health care. We'll attempt to bring into our submission their often less-than-positive experiences with health care and the government, whom they trusted to protect them. Their skepticism is justified.

The members of the Hepatitis C Network here before you are representatives of some of the populations most at risk for contracting hepatitis C. We include representatives of the aboriginal community, addictions and corrections. Our representative from the youth community is not able to make it today. The Hepatitis C Network was born of the concern and commitment of two of these groups: St Leonard's House, which is a halfway house for federal offenders, and members of the aboriginal community. We're a grassroots community collaborative that includes agency and consumer representatives. We receive no funding at any level of government. Nevertheless, for the past five years, we have provided services in this community, including care and treatment support, counselling, advocacy, outreach and education. In addition to presenting an annual conference, our outreach has taken us to such diverse locations as daycares and provincial jails.

A little bit about hepatitis C itself: It's a chronic, disabling disease caused by a viral infection that was first discovered in 1989. It spread rapidly through the blood supply. Today, it's estimated that 170 million people world-wide are infected, up to 300,000 of those in Canada. This causes grave concern that our health care system will be overwhelmed. Because most persons with chronic hepatitis C infection have yet to be diagnosed but are likely to come to medical attention in the next 10 years or so, we can expect a fourfold increase in the number of adults diagnosed with hepatitis C infection over the next decade.

For those new to the subject, hepatitis is a medical term that means inflammation of the liver. It causes swelling and scarring of the liver that leads to cirrhosis, which reduces the liver's ability to function. It has an initial phase that's acute. If it goes past six months, the virus is considered chronic. The progression of the disease is slow and unpredictable. As appendix 1 of our written submission indicates, out of 100 people who become infected with hepatitis C, approximately 80% will go into the chronic phase of the disease. Of those, approximately 20 people will develop cirrhosis after 20 years. The chance of developing cirrhosis increases the longer you have the infection. Approximately 5% of the group that develops cirrhosis will experience liver failure or liver cancer.

The extent of the problem in Ontario and in our community: In 2002, the last year for which annual statistics are currently available, Ontario reported 5,280 cases of hepatitis C to Health Canada's infectious disease surveillance program. But because only between one third and two thirds of those currently infected with hepatitis C have been identified, up to 60,000 Ontarians do not know they're infected, are not accessing treatment and are at risk of infecting others.

The local situation: Every couple of days, one of our fellow residents is diagnosed. A recent study funded by Health Canada confirmed the infection rates of Ontario's department of public health, indicating that infection rates in Windsor and Essex county are 19% higher than

the provincial average—5.8 per 10,000 people compared to 4.9 per 10,000 in the province.

Close to 1,800 people in Windsor and Essex county have hepatitis C. We had 163 new cases last year. We had 159 the year before. The number of people in our community at risk is close to 56,000, and includes marginalized populations, including the homeless, youth, mental health people with addictions, particularly those who are intravenous drug users, corrections—in which infection rates can reach 40%—as well as the aboriginal community, which also experiences elevated rates of infection.

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Windsorites and Essex county residents diagnosed with hepatitis C and their loved ones can be overwhelmed with this disease. Their search for accurate information and timely care and support is both frustrating and frightening. A family physician is most often the first point of access for people with hepatitis C, but because Windsor remains seriously underserviced both in terms of family physicians and specialists, it may take many months to access appropriate medical care and/or to commence antiviral therapy. We have no hepatologist or liver specialist in Windsor. Because of this, people who require treatment are referred to one of four gastroenterologists or they must travel 200 kilometres to the London health centre. This situation creates disparity in health care. While some of our clients can travel to London to access treatment and support, for others the cost of even one 200-kilometre trip to London is prohibitive.

Ontario's response to hepatitis C over the past five years has been mixed. Initially, Ontario demonstrated leadership in monetary compensation for those who acquired hepatitis C through blood transfusion or products, but the lack of subsequent action related to this disease has produced disparate and fragmented health care and community services that are unresponsive to the needs of all those affected in Ontario.

The government espouses the principle of accountability, and we'll have more to say on that later. For now, suffice to say that people affected by hepatitis C and those who advocate on their behalf are aware that Ontario received 44% of the \$300 million the federal government agreed to pay to the provinces as part of the 1998 hepatitis C compensation program. Ontario's share of this money is \$132 million. These funds are to go specifically toward providing programs of care and support for those infected with hepatitis C. By this year, Ontario should have received \$67.2 million. What has happened to it? Apart from the development of a hepatitis C advisory committee set up by then-Minister of Health Tony Clement to advise the government on hepatitis C, it's anybody's guess.

For all intents and purposes, the hepatitis C advisory committee has been disbanded. They've not met in over a year. Furthermore, members of the advisory committee, along with hepatitis C victims and their advocates, have for the past year repeatedly made requests of this govern-

ment, including the current Minister of Health, as to the status of the advisory committee and the tens of millions of dollars in the government's care. We haven't received a response. To date, there has been no accounting of these monies.

The government intends to commit to community care and an integrated health care system, but they have not done so yet with regard to hepatitis C. There was to be a comprehensive hepatitis C strategy that includes the support of community-based groups and organizations. Community organizations were promised a role in directing and monitoring this strategy, yet to this day, community groups and individuals continue to struggle to provide supportive services within a vacuum of resources.

The government talks about fiscal responsibility, but we have to question that as well. The hepatitis C epidemic is continuing to spread, and this consumes not only personal financial resources but also those that we all in Ontario share. Some costs to the province include: Every 20 people who die of hepatitis C related liver failure will cost our health care system \$1 million a year; every 40 people who require the antiviral treatment will cost our health care system another \$1 million per year; every 100 people who need to access provincial disability benefits because of the disease will cost the province close to \$1 million a year. Yet Ontario has not initiated a province-wide public awareness campaign to identify those at risk. The result is that from one third to two thirds of those infected will not realize they have the virus until the disease is very advanced. Because of the long incubation period, which can be up to 30 years, many will suffer with undiagnosed symptoms such as fatigue, depression and infections that may be severe enough to affect their work, home life and mental health.

Overall in Ontario, we suffer from a lack of co-ordinated health care that cuts across the silos of public health, hospitals, clinics, physicians, home care and pharmacare. We're pleased to see that the government intends to address that through integration. However, this lack of integrated strategy really is harmful in terms of hepatitis C. For instance, harm reduction programs directed at high-risk populations do not carry an effective hepatitis C message. Those of us who support high-risk groups are not effectively engaged and supported to focus on hepatitis C prevention. As a result, we can expect at least 2,000 new infections a year over the next five years. Those infected are not diagnosed, and those diagnosed face major barriers in getting access to appropriate treatment and supportive care.

Thank you for your patience while we walked you through the scope of this disease. I'd like to now turn our attention to the legislation before us. I will be speaking to part I of the legislation, the formation of the health council, and part III, which is accountability.

This bill establishes the Ontario Health Quality Council, part of whose responsibility is to report on important health care indicators in an effort to raise the quality of the health care system. We support that initiative as a

commanding first step in addressing some of the ailments of Ontario's health care system. Our concerns surround the composition and representation on that council.

First, subsection 2(3) of the bill says that the council is to be comprised in part of experts in the health system in the areas of patient care, consumer issues and health services provision. Our question is, who are these experts and whom do they represent? For the government to achieve its objective of consumer-centred care, as is stated in the preamble of this bill, the council must openly support the participation of health care consumers in decisions about their own care as well as those related to the responsible use of health care resources. Health care consumers deserve a place at the table. If that's not to be at the table of this particular council, then the council itself must develop some mechanism to allow for the direct involvement of consumers of health care.

The Minister of Health told this committee on Monday that the council does not advance individual stakeholder agendas but allows for the broadest perspective possible to advance the agenda of our most important stakeholders, the 12 million Ontarians who are counting on us all. We appreciate that orientation toward broadness and inclusiveness, but we'd like to point out that community stakeholder groups are those who have risen to fill gaps in health care, providing front-line service to the millions of Ontarians unable to access the service they need from their government. To exclude community stakeholder representatives from this process is to ignore a vast body of acquired knowledge and best practices from which the government could benefit, not to mention alienating the people the government needs to speak to and to whom they are responsible, and whose support is vital to the success of this mandate.

Second, as per subsection 2(4), it is the government's intent that an additional factor to be considered in the composition of the health council is that "regard shall be had to representing the diversity of the population of Ontario and expertise with particular groups." It is an unfortunate reality that regional disparities in health care services exist in our province. The experience of accessing health care services in Windsor and Essex county, for example, is very different and often more difficult than in Toronto or London. To reflect the province as a whole, we feel the health council should include in its diversification regional representation from underserviced areas.

In our opinion, it's important that the health council not become just another advisory body in an already dizzying array of bureaucracy. Its work must remain relevant, not only to government but to the people of Ontario who fund the health care system and are the consumers of its resources.

Third, this government recognizes that access to primary health care is a cornerstone of an effective health system. We support that initiative, but the preamble is short on specifics when it comes to primary health care. Romanow recognizes that there is no single model of primary health care that captures the diversity and needs of situations across Canada, nor is there one, we submit,

that would capture the needs of all Ontarians. The Romanow report identifies early detection and action as one of the four essential building blocks that define primary health care. The other three are in our written submission.

As outlined in appendix 3 in our written submission, a Preliminary Strategy to Address Hepatitis C in Ontario, we welcome any initiative toward developing a model of health care that promotes public awareness, early detection and action in preventing the spread of infectious hepatitis C.

Finally, while we support the government's intention to entrench accountability as a central principle in Ontario's health system, we note that as the present legislation reads, accountability appears to be a top-down process defined by matters, according to section 20, that the minister deems "to be appropriate in the circumstances," including shared and clear roles and responsibilities, transparency, fiscal responsibility, value for money, consistency and trust, amongst others. Moreover, accountability is imposed upon health care resource providers and/or any other prescribed person, agency or entity not identified in section 21 through the use of ministerial directives.

Is it the government's intent that accountability be a two-way street? We've had some conversations surrounding this today that I'm glad to see. If so, what proviso does the government intend to enact, if any, to ensure that the government itself is accountable to Ontarians? Again, the Minister of Health said this past Monday to this committee that, "Accountability isn't a burden we place on others. It's a responsibility we all accept and share, and I include this government and my ministry." We're hopeful that he will follow through on those words.

Our experiences, combined with those of victims of hepatitis C and even those of the government's own hepatitis C advisory committee, have shown us that the government is not yet fully committed to accountability. We don't feel we've received value for our money. In fact, we remain unable to extract from the government an answer to the question of where the money went.

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If the government has stringent expectations of accountability on the part of its partners in health care, ought not the people of Ontario have the right to expect their government to meet, if not exceed, those expectations? We don't feel this legislation makes allowances for Ontarians to exercise that right. It does not hold the government accountable for any of the qualities that it puts forth as being appropriate.

The minister has said that this government has a clear plan to transform health care in Ontario. If this is it, it leaves a lot to be desired. If this bill is a component of a larger plan, that needs to be made very clear to Ontarians. Ontarians need to be involved in this process. This process needs to be transparent and open. The government is asking the people of Ontario to trust that it has their best interests at heart, but we don't see that it gives us a reason to trust.

However, through this bill the government is indicating its readiness to come to the table, to collectively share roles and responsibilities with the people who fund this precious resource. We welcome this initiative, and we look forward to the day when we can play a more active role in a participatory process with an open and accountable government.

I've included recommendations in our written submission that I encourage you to read, as well as our preliminary strategy for hepatitis C in Ontario. I won't present them verbally.

Thank you very much, again, for your time.

The Chair: You've used up 16 minutes. That leaves about five minutes for each party. We'll start with Ms Martel from the New Democrats.

Ms Martel: Thank you, to the three of you, for being here this morning, bringing a brief that has a bit of a different perspective than many we've heard. We appreciate that very much.

First of all, I think you've raised very serious concerns with respect to where money has gone, what is happening to money that has, by all accounts, come to Ontario at this point—at least we understand it should have by now—and you don't have an idea of where it went. The second problem seems to be that the advisory council is not even meeting to determine what to do.

I think this committee would make a recommendation or a request to the minister to get an answer about these important questions for you that can be shared with your colleagues across the province. You deserve to have an answer, and it's not acceptable that you haven't yet, through two different governments. I think we can all agree that we will undertake to request that the parliamentary assistant that she get some answers for you that can be shared.

Ms Price: Thank you. We'll look forward to those answers.

Ms Martel: I think, both in terms of the money that has been spent and what is happening to the advisory council—is it going to start operating again? Also, when will a strategy for hepatitis C actually be developed? Who is working on that, who is involved and how can you be a part of it? Those are questions you need some answers to.

Let me just talk about the council for a little bit. What I want to focus on is the point you make, which is, "In our opinion, it is important that the health council not become just another advisory body in an already dizzying array of bureaucracy." I appreciate that you mention that, because the minister and I had an exchange on Monday about this very council. I am concerned that it will become a body, like so many others, that is monitoring and filing reports, and once that's done, the reports sit on the shelf, collect dust and nothing ever happens to address what's in the reports.

I had this exchange with the minister, because he also said that this was one of the accountability mechanisms for the government. You talked about, where is the government's accountability? He said the accountability

comes from the council. Well, it doesn't if the council doesn't even have the ability to make recommendations for change based on the reports. The council can't make recommendations about funding, can't make recommendations about change in health policy or in health legislation; the best the council can do is make a recommendation on what it might report on, which is, to my mind, completely unacceptable. They need to be able to do more than that.

Do you want to elaborate on the concern you expressed that this may be something else, just like the others, where very little gets done to actually change and improve health outcomes for Ontarians?

Ms Price: The intent of the council, I think, is good. The intent of the council is to oversee the system, to oversee accountability and to bring forward to the ministry those issues which are important to Ontario. However, like you say, we've seen other advisory bodies, we've seen other councils where nothing happens. A report gets filed and nothing goes forward. We feel that this bill is an attempt to be proactive in changing health care in Ontario, so we're really hoping that it follows through.

I think our primary concern is, where is the consumer's voice in this process? Consumers traditionally have not been given a voice in this process. We have health care experts and stakeholder groups and ministry representatives and everybody else, but our concern is where the consumer's voice is.

Ms Martel: And if they have a voice, what that voice says in terms of what needs to be done. Would you like to expand on that at all?

Ms Graham: What you said is correct. When we brought this up, putting in the idea that we could sit on this hearing today, some of the other members of the network said, "Well, it's just going to be another council that will be formed, and what's the point?" So we had to convince them that at least it's us getting our voice out again. But like Susan said, it's the community representation, and will these councils come to the local communities and sit down with the relevant consumers and hear first-hand what the struggles are that we hear on a daily basis from just the Windsor and Essex county residents who are dealing with this hepatitis C?

The Chair: We'll go on to Ms Di Cocco.

Ms Caroline Di Cocco (Sarnia-Lambton): Thank you for your input. I hear the cynicism, I guess, that comes through in your discussion, and I want to make a very strong point that I think is being lost here: This process of us as a government having a bill go to committee after first reading is quite remarkable. Why are we doing it? Because it's an important process that, as the minister says, welcomes vigorous review of the bill, which is a proposed bill.

Unlike the former administration, where it was a fait accompli when it went to committee, this is about getting input. It's a commitment to a better approach to enacting legislation and enacting law. Therefore it's a tremendously, I would say, positive approach to making laws

for this province because this hasn't had second reading. This input becomes a very dramatic influence, if you want, into the finalization of the bill. I want to make sure that's understood here. We are here to listen to the perspectives so that when we actually finalize this bill, at least it has had thorough scrutiny by the stakeholders, by the public, before it goes to second reading. I have to tell you it's quite a dramatic step, if you take a look at legislatures around the world, parliamentary systems. It truly is about the scrutiny roles that committees have on bills if those bills are shaped by the stakeholders after first reading. I'd like to make sure that point is certainly understood.

Again, I want to say it's very dramatic. I have been on committees for four years, and I have to tell you that the notion of having an amendment to a bill was almost non-existent. That's not the case now. It's a whole different approach to developing the bill. Thank you very much for your input.

The Chair: Mr Duguid.

Mr Brad Duguid (Scarborough Centre): I took notice of your suggestions and comments with regard to getting representation on the health council from the general public. When you have hearings on bills, when you have deputations on almost anything, you get a lot of participation from stakeholder groups, all of which is welcome but most of whom have their own agendas to bring forward. At the end of the day, for whom are we really doing this? We're doing this to improve the health care system for the general public. I had this discussion with one of my colleagues the other day: Whom can you get for a board like that who actually can represent the general public? Are you aware of advocacy groups out there that don't have their own agendas but are out there, whether it be to look after seniors or look after specific public interest groups?

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Ms Price: Not specifically. I'm quite certain that, province-wide and at every community level, you are going to find people capable of advocating on a number of different levels. We're advocating for people in terms of hepatitis C. If you were to look for a provincial spokesperson for hepatitis C, I would suggest Dr Wong-Rieger, who has been advocating on behalf of this disease for many years, quite loudly and quite vocally. I see some of you nodding your heads, so you're familiar with who she is. But I would hesitate to make recommendations concerning consumer advocates at any other level.

Mr Klees: I do appreciate your submission today. I want to just clarify something for the record. I think Ms Di Cocco has a lapse of memory, but we're going to cut her some slack. This is her first time in government. The fact of the matter is that it's not new to take a bill to the public following first reading. Our government certainly did that, and meaningful amendments were made.

She used the term "dramatic." Let me tell you, for the last four days since we have been travelling the province, the word used to describe this bill hasn't been

"dramatic," it's been "shocking," because first of all the minister, in introducing it, embarrassingly had to admit that this bill was seriously flawed. To say the bill is being submitted, maybe for shock value—had the minister read this bill before he actually presented it, he would have withdrawn it before it even came to committee, because the intent here, as you point out and as others have pointed out, is draconian. It's a top-down imposition of ministerial power and authority the likes of which this province has never seen before. That's why doctors, nurses, employer groups, unions, advocates, together, unanimously have condemned this bill. It is a terrible bill.

We hope, with your help in the kind of submission you have made, that the minister will see the wisdom of keeping the preamble of the bill, scrapping the rest of it and getting on with building a piece of legislation that can actually serve you folks and serve the people of this province in a positive way. Thank you for your submission. I think my colleague has some more comments.

Ms Price: Let me just respond to that briefly. In response to both of your comments, I would like to say that we are very new to this process. This is the first time we've been involved in any type of legislative process, so forgive me if we're not professional with it. But we really, truly appreciate the opportunity to bring the consumer perspective to the table.

Mr Tim Hudak (Erie-Lincoln): Thank you very much for the presentation. I had no idea it was your first time. You've done an excellent job and made some very good points for this committee's consideration.

I agree with my colleague Mr Klees's comments. I think the government went to first reading hearings because they realized that they had stumbled tremendously out of the gate. We haven't found anybody who actually likes this bill, except maybe printers, because they're going to have to print off scads of amendments to rewrite this bill from the preamble on.

There's one point I wanted to pursue with you. The one part they boasted about that I think actually falls well short of its hype—in fact, I think the health council could be a sheep in wolf's clothing, to turn the term around. They actually do what the minister tells them to do in reporting, and they report only to the minister. You made an excellent point about reports sitting on the shelf gathering dust.

I have two suggestions for amendments, and I want to know if you would support them. The first is an amendment that would guarantee consumer representation as part of that council, that there be at least one seat, if not more, designated for consumers only. Secondly, would you support an idea to have that council report to the Legislature in general, as opposed to the minister? The Auditor General's report in Ottawa, for example, was given to Parliament as a whole, which has caused greater publicity for what she had found, as opposed to just simply sitting in a minister's office.

Ms Price: Let me start with your second recommendation. I don't feel I have enough experience to recommend that a council report to any particular body of

government, although I would support that it report publicly.

To your first recommendation, I would definitely support that it be enshrined that a consumer representative from some area, be it hepatitis C, be it cancer, be it whatever, be at the table.

The Chair: Thank you for coming today. We certainly did appreciate your input, the comments that were made. You did an excellent job. If that was your first presentation, you've got a lot of good ones ahead of you.

Ms Price: Good. I look forward to being part of it. Thank you.

CANADIAN UNION
OF PUBLIC EMPLOYEES,
LOCAL 1132

The Chair: I call forward the Canadian Union of Public Employees, Windsor area office, Geraldine Carey, acting president of local 1132; Ann Huffmon, vice-president of area 1; and Brian Manninger from the CUPE council. Greetings. Make yourselves comfortable. Would you all identify yourselves for Hansard?

You've got 30 minutes. You can use that 30 minutes any way you see fit. At the end of your presentation, the remaining time will be split among the three parties for questions, supposedly, and we'll be starting with the Liberals this time.

The floor is yours.

Ms Geraldine Carey: My name is Geraldine Carey, acting president of CUPE 1132.

Mr Brian Manninger: I'm Brian Manninger. I'm president of the Windsor district CUPE council.

Ms Ann Huffmon: Ann Huffmon, area VP for area 1 of the Ontario Council of Hospitals.

Ms Carey: I'm going to start off the presentation. I'm going to give a brief history of Windsor and our union.

CUPE local 1132 represents RPNs, which is registered practical nurses, certified and non-certified rehabilitation assistants, and operating room technicians at Windsor Regional Hospital. These health care providers are the front-line staff who provide hands-on care.

We bring to this committee the experience of front-line hospital providers and, between myself and Ann, 50 years of experience. Many of our members have served Ontario hospitals for decades. Although we receive little of the glory, our work is vital for the functioning of Ontario hospitals. We provide the core of Ontario hospital services and are the backbone of hospital infection control.

Windsor Regional Hospital is a result of a merger between Windsor Western Hospital and Metropolitan General Hospital, which occurred about January 1, 1996. The Metropolitan hospital is the acute care sector; the western campus is non-acute.

The other two hospitals in Windsor are the Grace Hospital and Hôtel-Dieu, which are now known as Hôtel-Dieu Grace. The Grace Hospital closed in the early part of 2004.

In 1995, Riverview Hospital, a chronic care hospital which was part of Windsor Western Hospital at the time, was replaced and renamed Malden Park Continuing Care Centre and is classified as a long-term-care facility.

Along with the mergers, there have been program transfers that occurred on or about January 2000 with acute psychiatry and maternal/newborn, NICU and the sexual assault treatment centre. Acute psychiatry was to be transferred to Hôtel-Dieu, and to date is still not at that location. The maternal/newborn, NICU and the sexual assault centre were transferred to Windsor Regional; that was completed at the end of 2003.

During this period of time, CUPE 1132 members as well as other health care providers have gone through numerous layoffs, job losses, early retirements, and being bumped from one unit to another, along with service, program and bed cuts.

To date, CUPE 1132 has had several rounds of layoffs, the first starting in 1997 to the most recent in May 2003, when 100 qualified, experienced and competent registered practical nurses were removed from the acute care sector of the hospital and replaced with registered nurses. These events have created frustration, stress, workload issues and professional dissatisfaction, causing many of our experienced and vital nurses to take early retirement or leave the profession. We cannot afford to lose these nurses.

Implementing Bill 8 as it stands today will cause many more nurses and other health care providers to leave the health care system.

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The Ontario Liberal government introduced Bill 8, the Commitment to the Future of Medicare Act, with great fanfare in November 2003, less than two months after the government was elected. The government introduced this bill by emphasizing its support for principles that this union local and the Ontario public hold very dearly. However, the bill itself raises troubling issues. While the bill does set some worthwhile goals, these are either not achieved or the rights are already largely set out in existing legislation. But most importantly, the bill creates serious problems for the health care industry.

I'm going to hand this over.

Ms Huffmon: As I said, I represent area 1, and I think you should realize that area 1 encompasses Wingham, St Mary's, Clinton, Seaforth, Guelph, Stratford and Windsor, so it is a large area that we represent.

This bill does create some very serious problems within health care. The government said it would "make universal, public medicare the law ... and put an end to the creeping privatization of the system in recent years." This statement was made by Minister Smitherman on introduction of the bill.

Another statement made by Minister Smitherman was, "We are slamming the door shut on two-tier, pay-your-way-to-the-front-of-the-line health care in Ontario. This bill would enshrine into law what we already deeply believe in our hearts, that every member of our society

has an equal right to quality health care based on need, not income."

These certainly are statements that would have helped the Liberal government get elected.

When Minister Smitherman introduced this bill, he referred to the speed with which it was introduced, which causes us some concern, stating that it would help "ensure that new hospitals in Ottawa and Brampton will be publicly owned, publicly controlled and publicly accountable." His reference to the new hospitals is of deep concern to us. The Liberals campaigned against P3 hospitals during the election, and he has now introduced a similar P3 model that will affect Brampton and Ottawa. In these two areas, over \$1 billion of health care monies will be turned over to giant for-profit operations. It is really hard to see creeping privatization come to an end when things like this are happening. We have also learned that there are another six private hospitals on the docket that they can investigate for private funding. It raises the question again of how seriously we should take Bill 8 and what is the hidden agenda behind this bill. I have some real concerns about that.

Mr Manninger: Part I of Bill 8, sections 1 to 6, establishes the Ontario Health Quality Council to monitor and report to the public respecting (1) access to publicly funded health services, (2) health human resources in publicly funded health services, (3) consumer and population health status and (4) health service outcomes, and also to support continuous quality improvement.

However, the nine- to 12-person council will not deal with many vital issues. It cannot report on the extent to which the Ontario health care system conforms to the requirements of public administration, comprehensiveness, universality and portability—key provisions of the Canada Health Act—focusing instead on accessibility. Further, the council is not required to report on issues relating to two-tier medicine, extra-billing and user fees, despite the fine sentiments expressed in the preamble to the bill and by the government when it released the bill. The council is also specifically prohibited from making recommendations. In other words, the council only deals with accountability on a narrow range of issues.

Our greatest concerns, however, relate to part III, sections 19 to 32, of the act. Specifically we are concerned about the broad powers of the minister to require accountability agreements or to issue compliance directives. While the government has made much of the accountability set out in the act, it is notable that the accountability in this part of the act is accountability of health care providers to the government, not accountability of the government to the public.

These provisions have been drafted in extremely broad and general terms. They grant the minister virtually unprecedented power to require individuals and organizations to comply with ministerial health care initiatives. Potentially, these steps could override our collective agreements or other negotiated agreements.

Under the provisions, the minister can direct any health resource provider or any person, agency or entity

that is prescribed by regulation to enter into accountability agreements with the minister or with the minister and any person, agency or entity.

The term "health resource provider" is broadly defined. Unless the act is clearly and unequivocally amended, a trade union, for example, might well qualify under the broad definition of "health resource provider." Health Minister Smitherman has admitted that the bill needs amendment. We need to see the amendments in full to ensure that our families' futures are safe. We urge the government to bring these forward in full as soon as possible and not wait until March 9.

The minister is also empowered in section 22 to issue directives compelling health resource providers and any other prescribed person, agency or entity to take any action specified in the directive or to comply with prescribed compliance measures. There is little limitation on the scope of such directives.

The minister's discretion is as wide as the government determines it should be. These powers could be used for health care reorganization, hospital restructuring, privatization or other initiatives.

Section 27 of the proposed bill even provides that where an order makes a significant change in a person's terms of employment, including a reduction in compensation, the change shall be deemed to have been mutually agreed upon between the person and his or her employer. Is this a democracy or a dictatorship?

Under this bill, as written, a health care union and an employer could be ordered to address certain issues through collective bargaining and, in the event they fail to do so, could be subject to an order requiring them to reduce wages or benefits or to eliminate no-contracting-out or successor rights protections contained in collective agreements.

Similarly, the minister's powers under part III could be used to require hospitals to consolidate certain operations and require collective agreements to be modified to facilitate such initiatives; or, regardless of any restructuring, the minister could simply order a reduction in wages and benefits.

Taken together, all of part III can only be viewed as an attempt to bestow upon the minister and the government virtually unlimited authority to unilaterally order and direct fundamental changes to the health care system and to do so in a top-down, dictatorial manner, without any traditional procedural safeguards or substantive limitations. This is reminiscent of the omnibus Bill 26 legislation introduced by the previous Conservative government when it was elected in 1995.

We also note that health care privatization has been persistently criticized for reducing public accountability for a vital public service. Commercial confidentiality radically reduces the public's ability to find out how their dollars are being used. If the government intends to use this section of the act to attempt to counter this criticism while intensifying privatization, it should say so clearly now. To do otherwise would be to mislead the public about the government's intentions, particularly given how the government has introduced this bill.

We might add that the need for commercial confidentiality in the for-profit sector will largely frustrate any such attempt to impose accountability to the public on for-profit corporations. Commercial competition limits the ability of for-profit corporations to openly reveal their secrets, as doing so would reveal any advantages they have over their competitors.

Finally, we note that the bill seeks to insulate the crown and the minister from any legal liability resulting from any actions taken in connection with accountability agreements or compliance directives. On the other hand, anyone who fails to comply with an order by the minister relating to accountability agreements or compliance directives is subject to prosecution and, if found guilty, may be subject to a fine of up to \$100,000.

We are presently the main target of hospital privatization and restructuring. The privatization of hospital services in British Columbia has meant mass layoffs and a radical reduction in compensation. Our livelihoods, our homes and our retirements are on the line. So we take threats to our collective agreements very seriously, and we hope this committee will too.

We have recently lived through, and are still recovering from, the massive hospital restructuring under the previous Conservative government. In our view, the massive restructuring did very little or nothing to improve the hospital system. It did seriously disrupt the lives of tens of thousands of hospital workers. Constant change and restructuring do not serve the hospital system or its employees well.

While the last round of hospital restructuring did little to improve the previous government's popularity, at least there was a process in place for some consultation with the community through the Health Services Restructuring Commission. Bill 8 raises the possibility of restructuring through ministerial directive, a much worse possibility. We cannot understand why the Liberal government would choose to proceed in such a high-handed and brinksman-like manner. It raises great dangers for a health care system that has been under great stress for a number of years. We had hoped this would be understood by the new government.

1020

We note that British Columbia has also recently introduced agreements between the government and health care authorities that are similar to the accountability agreements proposed in Bill 8. Media reports indicate that the so-called BC performance agreements have connected the incomes of CEOs to the implementation of cutbacks in health care. We view this form of restructuring with alarm. We believe that hospitals and hospital managers must first and foremost consider the health care needs of the public at the hospital they serve. There should be no wedge driven between the hospital management and the community. This committee must consider this development seriously.

The community has gone through restructuring and layoffs. It is time to re-engineer our health care system and examine if our system provides the program or

services to Ontarians and ensure that there is appropriate funding. It is time to examine if we have enough nurses to care for the ill, and housekeepers, dietary providers, lab technicians, etc. It is time to enhance our health care system, not dismantle it.

We support many of the principles that the government focused on when it released this bill. Universal public medicare is Canada's most cherished social program. It helps define us as Canadians. We are not sure why the government chooses to introduce a bill that gives such sweeping power to the Minister of Health and Long-Term Care. However, legislation does not turn on the intent of the legislators. Its power rises from the meaning of its words.

We would like to pass on to you, in written form, key changes required to deal with our concerns with part III:

No trade union shall be required to enter into an accountability agreement or be the subject of a directive.

No collective agreement shall be the subject of an accountability agreement or of a directive.

No accountability agreement or directive shall directly or indirectly affect the continued operation and enforceability of a collective agreement or purport to amend its terms.

No employer shall be required or authorized to enter into an accountability agreement that directly or indirectly interferes with its ability to comply with the provisions of a collective agreement, nor shall any directive have such affect.

Notwithstanding sections 21, 22, 26, 27 and 28, no accountability agreement entered into under section 21, compliance directive entered into under section 22 or order made under section 26 shall directly or indirectly affect the continued operation and enforceability of a collective agreement; purport to amend, vary or discontinue the terms of a collective agreement; require the parties to a collective agreement to amend, vary or discontinue the terms of a collective agreement; or directly interfere with the ability of parties to a collective agreement to comply with the terms and conditions of a collective agreement.

We also believe that the government should reconsider the powers the bill may give to the Minister of Health and Long-Term Care to reorganize and restructure health care. The hospital system has already undergone extensive reorganization over the last 10 years. Allowing the minister to unilaterally impose more is a recipe for strife and chaos that may well push hospital employees still dealing with the previous round of restructuring to the brink.

On behalf of CUPE, the Ontario Council of Hospital Unions and Local 1132, thank you.

The Chair: Thank you. I do appreciate your submission. You used up about 18 minutes. That leaves us 12 minutes to split among the three parties, starting with the Liberals for four minutes.

Mr Duguid: Thank you very much for your submission. It was very detailed. I appreciate that you got through it in pretty good time. When I looked at it, I thought you were going to use the whole 30 minutes.

You talked about stress—your members being in a stressful situation. I think we all recognize that being the case. I have a sister who's a nurse at North York General Hospital in Toronto. She was on the SARS unit, so she knows and has told me that not only the RNs but many of your members operating right now are still in a bit of a burnout situation from that crisis.

You also mentioned that your members are very concerned about the accountability agreements and the impact they may or may not have on collective bargaining agreements. I'm just going to read a letter that was sent to your president, Sid Ryan, just to give you some assurance. This is a letter from the minister. Perhaps I can get your comments on it. I'd be interested to know whether the conversations Mr Ryan had with our minister in January were brought to your attention. The letter from the minister reads:

"I am extremely troubled by recent statements from CUPE that Bill 8, the Commitment to the Future of Medicare Act, will allow for opening collective agreements and threaten the job security and livelihood of Ontario workers. This is patently untrue.

"Here are the facts, the same facts that I told you during our meeting on January 13.

"The intent of Bill 8 is that accountability agreements are established only with board of directors of publicly funded health care institutions. Labour unions are not subject to and will never be subject to accountability agreements. Bill 8 cannot open collective agreements. You know this, because I told you that when we met. In fact, during our meeting I conveyed our openness to explicitly state in the bill that labour unions are not subject to the legislation.

"Further, collective agreements are protected by various pieces of legislation in Ontario. Bill 8 will not reduce that protection."

In that letter, it's pretty clear that Mr Ryan was advised of this back on January 13. I just want to ensure that you've been informed that in fact the minister has made that commitment.

Mr Manninger: Yes, we are well aware of the letter that the minister sent to Brother Ryan. In the letter he states a lot of good things. What we need to do is see those things in amendments before this committee. At that time, we will accept the letter at face value, when they are here.

Mr Duguid: I recognize that, and I guess what I would ask from you, given the stressful situation that your members are in, is that, when you get those amendments, would you endeavour to make sure that your members are made aware that in fact there was and is no intention to impact on the collective agreements?

Mr Manninger: Once we see the amendments to the bill and once they prove satisfactory to us, we'll by all means communicate this to our membership across the province.

Mr Duguid: We'd appreciate it if you did, because we recognize the stressful situation they're operating within now. I think the last thing we want to do is have infor-

mation not clarified for them when there's nothing that they should be stressed out about on this particular thing.

Is my time up?

The Chair: You've got about 30 seconds.

Mr Duguid: The second thing is, you talk about the draconian impact of the bill in terms of the accountability agreements when you are not able to get an agreement from a hospital board. You're aware that under the Public Hospitals Act the province has the ability to step in at any time and take control of a board in a hospital. Given that, do you recognize that what's being attempted here is, when we do have a rogue board or a board that doesn't want to implement an accountability agreement, to find a process where we can work with that board and ensure that they do in fact comply?

The Chair: It will have to be a very brief answer.

Ms Huffmon: We are aware the government does have those rights, but our concern is that when they're trying to balance budgets they always start with the lowest worker first and work their way up, and then they are rewarded for balancing their budgets. That is one of our greatest concerns. It has to be across the board, I guess would be the appropriate way of saying it. I'm very new at this myself, so I'm hoping I'm getting this right. The front-line worker has to be protected. There's no protection for them within this bill.

The Chair: I think that makes it very clear. You've run out of time, but I think you've summarized well.

Mr Klees: Thank you very much for your presentation. I might say to you that I share your cynicism, along with every other Ontarian. Whether it's this minister or the Premier, having made many, many promises that they haven't kept so far, why should you or Mr Ryan believe them now? You have a right to see these things in writing. That was precisely the point we made in committee in Sudbury when we had a similar discussion. We gave the Liberal members of the committee an opportunity to demonstrate their commitment to the very things that Mr Duguid is saying. At that time, I moved a motion that this committee in fact support the very specific amendments that you're proposing to put some teeth into the promises. Do you know what happened there? We voted for it, Ms Martel voted for it, and every single member of the Liberals sitting on this committee voted against it.

1030

I'm going to give them one more chance here. I'm going to move a motion now that this committee support specific amendments that guarantee that collective agreements will not be opened, that will guarantee all the things you rightfully request for front-line, health care workers in this province. You may observe that. We will be very interested to see whether the Liberal members of this committee perhaps have changed their minds. Perhaps today they'll agree to vote in favour of this amendment.

Chair, I would like to read into the record this motion, with your permission.

The Chair: Submit it in writing and then we'll get it copied.

Mr Klees: Yes, I will.

I move that the committee support incorporating the following amendments into the bill:

No trade union shall be required to enter into an accountability agreement or be the subject of a directive.

No collective agreement shall be the subject of an accountability agreement or of a directive.

No accountability agreement or directive shall directly or indirectly affect the continued operation and enforceability of a collective agreement or purport to amend its terms.

No employer shall be required or authorized to enter into an accountability agreement which directly or indirectly interferes with its ability to comply with the provisions of a collective agreement, nor shall any directive have such effect.

Notwithstanding sections 21, 22, 26, 27 and 28, no accountability agreement entered into under section 21, compliance directive entered into under section 22 or order made under section 26 shall (1) directly or indirectly affect the continued operation and enforceability of a collective agreement, (2) purport to amend, vary or discontinue the terms of a collective agreement, (3) require the parties to a collective agreement to amend, vary or discontinue the terms of a collective agreement or (4) directly or indirectly interfere with the ability of parties to a collective agreement to comply with the terms and conditions of a collective agreement;

And that these amendments be incorporated into the appropriate sections of the proposed Bill 8;

And that they be given every consideration during clause-by-clause.

The Chair: If you would submit that in writing—it sounds like it's the same motion that was passed before. We're going to confirm that.

Mr Klees: No, it's not.

The Chair: OK. We'll just confirm that. If it's not the same motion, then it will be in order. If it's the same motion, of course it would be out of order.

Mr Klees: I made sure that it's not.

Mr Hudak: Mr Chair, is there debate on the motion?

The Chair: There will be debate once we see if the motion is in order. The clerk is going to take a look at the written copy.

I was going to suggest that we move on with your time perhaps, Ms Martel. Before it's copied, we want to confirm it's a motion that's in order.

Ms Martel: Do you want me to start or wait?

The Chair: I think you should start.

Ms Martel: Thank you to the three of you for being here. You must be as intrigued as I am with the Conservative members' new-found respect and concern for trade union members and trade unions. It's the most amazing conversion on the road to Damascus. They haven't even slagged union bosses once during these hearings, so it's a quite amazing change. I wish I had seen some of that concern during the eight years they were in government. I bet you feel the same as I do.

Let's get to the heart of this. I want to ask questions in two areas: one, the compliance directives and what they mean; and second, privatization.

You heard the letter from Mr Ryan. You note that you didn't hear anything about compliance directives. In fact, in the section on compliance directives the minister could, by the back door, order amalgamation of food services, for example, or contracting out of food services, or contracting out of laundry services. That would have an impact, not particularly on your members in this local but probably on CUPE members and others right across the province. How do you feel about a letter, when we haven't seen the amendments yet, that doesn't say anything about compliance directives and what can be done by the back door through that mechanism?

Mr Manning: I think we stated that already, but the fact is that the letter is a piece of paper with a lot of good intentions on it. We need the amendments. The amendments need to deal with everything that we asked for in our presentation. Until we see such, we have to fight this bill.

Ms Martel: You need to be looking not only at the sections around collective agreements, but particularly at the compliance directives to see what, if any, changes are there.

Let me talk about privatization. The front of the bill talks in glowing terms about medicare. Who wouldn't support the preamble? Everybody would, except there's a huge gap between the government's talk about two-tier medicare—which is cheap, frankly, given what they're already doing—and actually having details in the bill which would stop the P3 hospitals or stop the private MRIs or stop competitive bidding in home care, none of which appears in this bill, which is very strange.

You hit the nail on the head when you talked about commercial competition limiting the ability to get accountability. We were in Ottawa yesterday and moved a motion asking for the P3 deal at the Royal Ottawa to be released publicly, because the Minister of Health had announced that it would be before the end of December, and it hasn't. One of the Liberal members, Mr Levac, cited commercial confidentiality as the reason why that particular deal shouldn't be released and the details shouldn't be released, because it might force the company to flee. I would like the private consortium to flee, because I want public hospitals built with public money, financed publicly and publicly administered, publicly delivered. I don't want the private sector to be anywhere near hospital building in this province.

Does it surprise you, given what happened in Ottawa yesterday and given the fact that there are no details in this bill whatsoever to stop P3s or to stop the private MRIs—do you really believe that the government is interested at all in stopping the further creeping privatization in Ontario?

Ms Huffmon: It doesn't surprise me at all. I also believe that part of this bill, the introduction of it—through research I've done, I also believe that it is opening the door for P3 hospitals. I think the accountability and the compliance will help dictate what is going on with the private organizations so the government can step up and say, "We do have a bill to protect you, so we can

make sure that these for-profit hospitals are really doing what we want them to do. You're going to have to pay, but we're pretty sure that we're going to make sure that they do what we want."

I think this bill has a secret agenda of paving the way for the P3s, which I don't support at all.

Ms Martel: There's no doubt that people are going to pay; they're going to pay more, because it costs the private sector more than the government to borrow money for financing. The private sector is not going to do this for free; they're going to want a 10%, 15% or 20% profit. So when hospitals have to find money in their operating budgets to pay the Liberal mortgage versus the Conservative lease, we're all going to pay more. That's money that should be going into patient care, not into profits for the for-profit corporations.

Are you cynical at all when you hear the nice words from the minister that say, "We support medicare; we're going to stop two-tier, creeping privatization," and then you look at the details and there's nothing there? In fact, the Liberals are continuing down the road started by the Conservatives with respect to privatization of health care. Does that make you cynical at all, especially given the promises they made during the election about these matters?

1040

Mr Manninger: We're totally cynical. They campaigned on P3 hospitals and that they'd do away with them. They have done nothing yet, to our knowledge, to move away from P3s. So the cynicism is there.

"Private" means "profit." We're in a non-profit sector. We provide it at cost, and to take it private is going to cost more money—no question about it. P3 hospitals are not a good thing. Anything P3 is not a good thing. It costs more.

The Chair: Thank you for the delegation. We certainly appreciate it.

We did have a delegation scheduled for 10:30 from the Ontario Medical Association. Just out of interest, are there people here yet from the Windsor and District Labour Council? OK, good. At some point we may be moving you up a little earlier than 11 o'clock. Is that fine with you? Is everybody's here who needs to be here?

Interjection: Yes.

The Chair: We're going to deal with this issue, then we'll move right on to you.

It would be far preferable if the mover of the motion was in the room. Mr Hudak, I'm going to rule this out of order on two points. If you'd like to defend those two points, that would be fine. If you'd like to take a second to bring Mr Klees in, I'd accept that too.

Mr Hudak: Chair, my colleague is just responding to a media request about the motion in particular. I know that he and probably the media would like to be here to see the vote. If we have a couple of minutes to wait for Mr Klees to return—

The Chair: Well, I don't think the committee waits for the media. If you'd like to bring him in, I'll wait a few seconds. If not—

Mr Hudak: On a point of order—

The Chair: If it's a real point of order, Mr Hudak.

Mr Hudak: You're going after my point of order before I even start speaking about it. The motion has just been brought forward to us for consideration. I anticipate that you'll be ruling momentarily on whether this is in order or not. I believe Mr Klees did indicate that this motion is different from a motion that the committee may have considered before. I wasn't there in Sudbury. My point of order about the motion being in order—I wasn't there in—

The Chair: I haven't ruled it out of order yet. I don't know what your point of order is; I'm waiting to hear it, and I don't hear it. If you'd like to bring Mr Klees in the room right now as I rule on it, that would be fine. That's what I'm saying. I don't think it's the role of the committee to wait for the media to finish an interview.

Mr Hudak: Fair enough. I appreciate that you want to have Mr Klees in the room to hear your ruling on the motion, but my concern is that this motion is different from the motion that the committee has considered before.

The Chair: Why don't I just rule on it, then, and we can deal with that?

On two points the clerk has advised me that this motion would be out of order. The first one is that even though some of the wording may be a little different, the motion is substantially the same motion that was moved in a previous meeting and was defeated. Also, by moving this motion, it would be, in effect, asking the committee to move to clause-by-clause, which it planned to do on March 9 and 10. If it was the wish of the committee to move to clause-by-clause at this time, certainly we could deal with the amendment. That is my ruling.

Sorry, Mr Klees, I've just ruled your motion out of order on two points. I can briefly summarize them. It didn't take me long. One is that, even though the wording may be a little different from the motion that was previously dealt with and lost, the substance of the motion is really the same. The other point is that by moving this motion at this point in time, which is something I'll honestly say from the chair that I don't understand why we allowed the other day, is that you would, in effect, be asking the committee to move to clause-by-clause at this point in time, which it has scheduled and agreed to do on March 9 and 10. That's the ruling of the Chair. If you would like to appeal that ruling, then we can certainly put it to a vote, but there's no debate on the ruling of the Chair.

Mr Klees: What I would ask is that you allow me some clarification. The wording, I thought, was very clear, and that is not that I move the amendment. Would you read back to me, please, for the benefit of all, precisely what my wording was in the introduction.

The Chair: What I have before us is: "Move that the committee support incorporating the following amendments to the bill."

Mr Klees: So my wording was very carefully chosen. I'm not debating the Chair's ruling.

The Chair: I made the ruling. The ruling can be appealed. I'm giving Mr Klees some latitude to explain what he was attempting to do. The ruling does not change. The motion is out of order, unless the majority of the committee decides that it is in order.

Mr Klees: That would be my next request, and that is that while technically—and I certainly would never dream of challenging the Chair in his wisdom, but what I would do is appeal to the rest of this committee for the benefit of demonstrating to the people who are here their willingness to put on the record support for incorporating very specific wording that this committee unanimously, notwithstanding the technicality involved, agrees to have a vote on this motion.

The Chair: Thank you, Mr Klees. So you aren't appealing the Chair's ruling?

Mr Klees: No, I'm asking for unanimous consent of the committee, and the parliamentary assistant refuses to grant that.

The Chair: OK. The motion is dealt with. Thank you for your patience.

WINDSOR AND DISTRICT LABOUR COUNCIL

The Chair: We're moving on to the Windsor and District Labour Council. We have, as I understand it, at least two people, and perhaps three: Gary Parent, president, and Peter Pellerito, political education chair. Please come forward and make yourselves comfortable. Pour yourselves some water, if you wish. You've got 30 minutes to use any way you like. At the end of your presentation, the time that is left over will be split among the three parties, starting with the Progressive Conservatives.

Mr Gary Parent: Thank you very much, Mr Chair. I can't help but say at the outset that I never thought that in the city of Windsor we'd be supporting a Conservative motion, but it certainly sounded like one we could support, but only in Windsor could that happen.

My name is Gary Parent. I'm the president of the Windsor District Labour Council. With me is Peter Pellerito, who's the chairperson of the political education committee of the council. What I would do is ask Peter to start our presentation.

Mr Peter Pellerito: Just before I start the presentation, I can't help but make a couple of comments.

First off, I've been on the board of directors of the Windsor Regional Hospital for nine years, and I am a sitting member of one of the committees of the hospital right now as well. I guess that's kind of a plum for me to stay involved with the hospital here in Windsor.

One of the comments I want to make, and I'm sure Brother Parent will touch on this, is that we have been consulted to death when it comes to health care in this community—from about 1992, if I'm not mistaken. Gary will probably touch on the Win-Win report and a whole bunch of other consultation processes that have taken place in health care.

I just want to make the comment that in the nine years I've been on the board of directors of the Windsor Regional Hospital, I can tell you that we've been told Windsor does one hell of a job by three governments, but when it comes to doing some of the things we propose in Windsor, none of you has listened to us.

The other point I want to make is on this cynicism thing. It's very difficult: With all the consultation processes that have taken place over the last 10 or 12 years, nobody has listened to us. I'm hoping this committee will go away and actually listen to what the people in this community are saying. Let me start the presentation.

1050

On behalf of over 42,000 members of the Windsor and District Labour Council, we want to thank the committee for the opportunity to speak to you today on our health care system here in the province of Ontario.

I also want to make the point that we didn't take any specific area in the bill, because we've taken a brush and sort of touched on all the aspects of health care.

As we look at the preamble of Bill 8, the fundamental Canadian values which make up the five principles of medicare—administration, comprehensiveness, universality, portability and accessibility—seem to be there, but the actual legislation doesn't provide any significant new initiatives with respect to these principles.

A number of people have already mentioned the Romanow report. We don't know what people are waiting for to implement some of those recommendations. We fail to see anything that would absolutely deter support of a two-tier medical system, extra billing, user fees.

The closure of two acute care hospitals here in Windsor and Essex county has created longer waiting lists for services that were promised to be improved. In turn, this has made queue-jumping attractive to those who have the ability to pay.

There seems to be a new section in Bill 8 that is supposed to limit the ability of individuals to jump the queue. It seems to state that an insured person cannot pay or confer a benefit in order to receive a preference in having access to insured services, nor can a practitioner charge or accept money for granting such preference.

The problem we see with this is that it prevents queue-jumping from occurring with insured services only. However, with more and more delisting of services, this provision would not be effective, as queue-jumping could occur within the ever-increasing delisted services. The major threat, in our opinion, is the shift from public to private health care services, which must be stopped and reversed.

Let me make another comment here. We're talking about MRIs and CAT scans and things of that nature. It's interesting that money was made available by the previous government, and it hasn't been stopped yet by this government, so private enterprise can come in, put their MRI clinics into service and then take money out of the public system. To me, it doesn't make sense. In this community, we know what the waiting list is. Our

hospitals have asked for another MRI, but because of our population, we can't get another MRI. We're trying to find an avenue through Cancer Care Ontario and our cancer centre to get another MRI, which I think is ridiculous, because we have the waiting list. We have doctors asking for these tests, and yet our waiting lists are longer.

The new government in our province campaigned against privatization of health care, yet we see them looking at going even further than the Conservative government they defeated with public-private partnerships, or P3s, and even now they are looking at privatizing more than just the three already talked about.

The thing that amazes us is the fact that this government is even looking at this model when it has been estimated that such private models can be expected to cost at least 10% more than their public sector equivalents. So in addition to the evidence from other such experiments in Britain and Australia that suggests P3 hospitals would include a deterioration of hospital services and diminished accountability, we already see private stand-alone clinics such as MRIs and CTs operating outside the public medicare system and draining money from it through third party billings: WSIB and insurance. The reason we feel this is happening is the government's lack of front-line staff funding for these services so they can be a revenue-generating source for the hospitals. We might also add that this further enables queue-jumping for so-called medically unnecessary services.

Block fees: We've also seen in our community many family physicians charging patients annual or block fees for a range of services, even though this has not been regulated.

The proposal in Bill 8 specifies that the government, not the physician, will determine whether and under which circumstances block fees can be charged, but our feeling is that they should be banned altogether. These fees have caused unnecessary anxiety to our retirees and their spouses, who, as we are well aware, are in much more need of medical attention in their twilight years.

Just before Gary starts, in my retirement now I've taken on the job of taking care of my parents. Just to give you an example of what is happening, my dad has been going through some pretty tough situations right now, and to top everything off, he's had a bout with the gout. Last week, just to show you how crazy this is, the nurse first calls home and tells me the problem that my dad has, but in order for her to get the prescription, my dad needs to pay another \$25 so that the doctor can write the prescription, and again, any follow-up—there won't be any more fees—for a \$12 prescription. I think that's disgusting.

My dad is on a fixed income. He retired over 20 years ago—he's going to be 86 in May. Now he has to pay—you know, it was only \$12.45, but if he had to get that prescription again, he would have to pay the doctor another \$25. The other reason we paid for the prescription was because it wasn't covered under the

government's plan. So those are some of the things that are happening in this community.

Mr Parent: Thanks very much, Peter. I just want to expand a little bit, because on my way to the hearings today, CBC had the president of the Essex County Medical Society on. Of course, one of the things the physicians obviously are against is the whole question of getting—leading the whole question of block fees. He used the analysis—and I think this is something the committee will probably hear this afternoon when they make their presentation. I believe he said they used to receive 90% funding from OHIP for their fees for services. They now receive 60%. So the only way they say they can make up the 30% or 40%, depending on what type of math you want to use—he was using 40%; I don't know, it must be the new math to get to 90%. But anyway, he's saying at that particular point in time that's the only way they can keep their heads above water. That is one of the pressures that is leading family physicians to abort their particular practices at a more regular rate.

I guess all I say to this committee is that it should be looking at the payment to physicians so they wouldn't have to cause undue hardships to people they want to extend care to at a rate that these block fees are talking about. I deal with our retirees—and we have over 5,000 retirees in my local union alone,—and I can tell you that one of the contentious issues they have is the whole question of paying this annual fee to a doctor. If you don't pay it, you pay the price of waiting longer in their waiting rooms while other people, who paid the block fee or annual fee, get moved up. That's something I think the committee should be looking at as well.

Accountability agreements and compliance directives: I would like to take a closer look at Bill 8, part III, sections 19 to 32, which cover the powers of the Minister of Health to compel persons to enter into accountability agreements or compliance directives. Our area of concern is that we feel the provisions have been drafted in such a way as to give the minister unprecedented power to require individuals and organizations to comply with whatever the minister desires, potentially including the overriding of collective agreements and other negotiated agreements. In our opinion, this constitutes a fundamental affront to the people's rights in a democratic society. Thus, Mr Klees—you weren't here at the beginning—it is very unusual that this labour council would support a Conservative motion, but we certainly support it today.

We want to be clear that we are opposed to the sweeping powers Bill 8 seems to be giving to the minister, as they appear to be too broad and too open-ended. As we have stated before, the labour community is much in favour of a high quality health care system which would include value for monies paid into the system. But to give these wide-ranging powers to one person would, in our opinion, leave the door too wide open to possible further privatization in the name of being fiscally responsible.

I want to just digress for a minute because Peter alluded to the Win-Win report. This community was a

pilot in the early 1990s in relationship to trying to change the way health care is being delivered in this province. We were—and I say this very seriously—the sacrificial lamb. This community banded together. We had over 4,000 volunteers who came together. I think Ms Martel will remember that particular time, because they were in government at the time. This was something that was looked at even before we went forward with it; we as a community had started a process that now jumped into Win-Win. Hundreds of volunteer hours went into trying to put a plan together that saw that we were going to reduce our five acute care hospitals to three. The savings from those two other acute care hospitals were going to be reinvested into this community in community-based services.

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Unfortunately, in 1995, with the election of the Conservative government, we saw that report sit on a shelf. But the continuation of the dismantling of the two acute care hospitals continued. At the same time, those savings did not get reinvested into this community, thus, as we've stated in our brief, causing the unduly long delays we're experiencing day in and day out. I know that when you were in government, the area members—Dwight Duncan and Sandra Pupatello and others from the NDP—were constantly badgering the government of the day that what was happening in our province had a relationship to some of the changes in policy that were made.

Some of the further things that I'll talk about in our brief again extended to this. One of them—I'll digress again and read it as I continue. Our long-term-care facility: For 25 years this community fought to change Riverview chronic care hospital into Malden Park long-term-care facility, and we did that; we raised the money. Finally, the government at that time, the NDP government, said they were going to do that. In that change, there was a commitment on funding, I believe \$290 per patient, whatever it was. But in 1995, what did we see happen? It was just a drastic cut in that per diem and costs committed to this community. What have we seen as a result? We've seen patients suffer and families being destroyed as a result of these particular cuts for the ever-rising elder population we have in this community. Quite frankly, we don't have a commitment from this government, nor does it show in this particular bill, that those types of changes are going to be reversed.

Long-term care and children's mental health care: We would be remiss if we didn't raise with the committee other issues that concern us here in Windsor and Essex county, such as the need for additional long-term-care beds. We have seen the closure of one of our oldest, well-respected homes, Villa Maria, because of underfunding from the province.

As a community, we fought very hard for many years, as I stated, to replace Riverview chronic care hospital with the new Malden Park long-term-care facility in the early 1990s. This facility was left vulnerable, as the appropriate funding promised by the government was taken away. In our opinion, this is nothing more than an

act of treason on the part of any government, after this community worked so hard to raise monies to meet the growing needs within our community.

As well, something has to be done on behalf of our children, who still have to sit on long waiting lists before their mental health care needs are met. It is absolutely criminal that in 2004 this would still be allowed to happen.

Conclusion: It is our hope that this bill will explicitly prohibit a two-tier health care system.

We would hope that accessibility will be strengthened, not weakened, especially for those communities that are currently underserviced as well as those communities that are geographically remote. You're sitting in one of the most underserviced communities in this province, that being Windsor, and Sudbury being another one in the north.

We would further hope that portability be included, as Ontario currently is not covering services for people from other provinces.

We demand that you live up to pre-election promise and put a stop to the current P3 hospitals being eyed for privatization as well as any others that have been talked about in the media over the last several months that the present Liberal government is looking at. Privatization of our hospitals in any form was rejected by the voters of Ontario, and to betray this faith will lead to voters saying, "Same old, same old, no matter who is in office."

The government has a chance to make a difference by ensuring that our health care system remains publicly funded and administered, universally accessible, portable and comprehensive.

We want to thank you on behalf of the total labour movement for the chance and opportunity to speak to this committee. Your task is great, but let me tell you, the people in this province deserve and want a publicly administered, universally accessible health care system, one that we have always been promoted for around the world. We're slowly but surely slipping into a private, two-tier health care system. We have to put a stop to it. This committee has in its mandate and in its charge to try and prevent that. It's not there in the current Bill 8.

As to the amendments, obviously the proof will be in the pudding, as has been said by many around this table. I did hear the minister the night of his presentation to the committee in Toronto. Yes, it sounded great, but we have to see what these amendments are. We have to see not only the amendments but the regulations that are going to govern this bill. Sometimes the regulations are worse than what is in the bill. I don't know if it's allowed, but maybe consultations should take place on the regulatory part of it so that public input is received. What may work in Toronto—guess what?—doesn't work in Windsor, doesn't work in Chatham, doesn't work in Sarnia.

God almighty, we have to have a universal health care system in this province that's going to be the model for everybody across this country. We have a population that's willing to pay the price for it if it's through taxation, but we can't do it when they continually see their

taxes going up and their services going down. You can't have it both ways. We need to have a health care system that's going to be for everybody in this province, not just a few who have the money to pay for extra services.

Thank you very much for your time.

The Chair: Thank you, Mr Parent and Mr Pellerito. We've got about four minutes left for each party to ask questions, starting with the PCs.

Mr Hudak: Thank you, gentlemen, for your presentation and the passion behind the points you brought forward. I think you're right. I think you have good reason to be cynical about what the true intentions behind this bill were from the outset. While we may have a bit of an apology letter, if you will, from Minister Smitherman to Sid Ryan, which was discussed in earlier presentations, that writing may be in the very same penmanship their platform was. You mentioned a couple of things. They had said they were going to get rid of the P3 hospitals, and there was a very clear debate in the election campaign. We as Conservatives had brought that idea forward, made the points again. Shelley Martel and the NDP were against it, and Dalton McGuinty and the Liberals were against the P3s. But now, after the election campaign, they've gone ahead with them in Dalton McGuinty's own area and they're looking at six others that we were told about earlier today. So I think you have great cause for concern, and that's why my colleague brought forward the motion to try to get the committee—and it should be the committee that tells the minister what's going to be in the bill, not the other way around. They have a chance to actually make amendments like those that have been brought forward today. So we've heard a lot of lip service but very little action.

Points were brought up a bit earlier—I think you gentlemen were both in the room—with respect to the quality council and whether it's actually going to have some teeth or are just do the minister's bidding and have some report that's finished sit on the shelf. What do you feel about ensuring that there's consumer representation on that panel as well, as opposed to the discretion of cabinet only?

Mr Parent: I absolutely, unilaterally agree that there should be consumer representation on that particular council. There should also be front-line staff. When you call health care experts, who are those experts? I feel, quite frankly, that it's the front-line staff. They're the people who deal, day in and day out, with the whole question of health care service delivery. They're the ones who can't make the calls to the patients because of understaffing. They're the ones who know first hand. Don't listen to the experts who may be sitting in an office somewhere trying to influence decisions being made in health care. If this committee and this government are interested in hearing at first hand what the concerns are and what the needs are in a particular health care setting, then it should be from the front-line staff somehow being represented on that council.

Mr Hudak: And as you both mentioned, there's a great deal left to the regulatory process. Regulations are

simply brought forward by the Minister of Health to cabinet and they're filed and they become empowered, become the law of the land, if you will. You made the suggestion that the regulations to major parts of this bill should go back to committee or for some sort of public input. That will give a chance for the government side and maybe the parliamentary assistant to respond to that request. Because this bill is going to be changed substantially from when it was introduced—a lot is going to be left in the regulations—that certainly seems like a very reasonable proposal that we would support. I would be curious if the government would respond favourably to hearings on the regulations as well.

Mr Parent: We'd be interested to hear that as well.

The Chair: You still have about a minute left, if you've got—

Mr Hudak: Yes, I've got another question on the health council as well. There are two types of reporting mechanisms of bodies. They can go to the minister, in which case the minister would receive the report, sort of put his or her own spin on it and then could put it out publicly or not. There are others that report to the assembly as a whole. The auditor, for example, does that, and we've seen what's happened in Ottawa as a result of the auditor's public report through Parliament. Do you like the suggestion that the health quality council should report to the Legislature publicly as opposed to simply going through the Minister of Health of the time?

Mr Parent: Listening to the conversation and your point this morning, I'd have no problem with that. In fact, I think it should be part and parcel. I think the Legislature should have responsibility over it, not just the minister himself or herself. It should be the responsibility of the Legislature in total.

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The Chair: Ms Martel?

Ms Martel: Thank you, Chair. Thank you, Gary and Peter, for being here this morning. I appreciate it very much. With respect to public consultation on the regs, it's interesting that this is not a proposal that's in the current bill. We just finished dealing with amendments to the health care bill, Bill 31, last Monday and the bill specifically states that there will be a public consultation process on the regulations. It was also out just for first reading, so I'm not sure why the government didn't include a similar provision for this bill, which is also out for first reading. It's an amendment that will now have to be brought forward.

I want to go to your conclusion. At the top you said, "It is your hope that this bill would explicitly prohibit a two-tier health care system." Well, it was my hope too. It was especially my hope when I read the preamble and heard all the glowing words about saving medicare and our system of publicly funded health care services and we're going to prohibit two-tier medicine, and then I look at the contents of the bill and see that there's nothing to be found. If it were a priority for the government to prohibit two-tier medicine, then that would have been in this bill on the first round, at first reading—if it were a

priority. I don't think it is a priority, and I think that's why it doesn't appear. I would bet my bottom dollar that it's not going to appear in the amendments that come forward.

Let's just contrast what the preamble says and what's not in the bill. If you look at our system of publicly funded health services, P3 hospitals, which the Liberals promised to cancel, have now become P3 hospitals under the Liberals. I like to refer to it as a Conservative lease now being replaced by a Liberal mortgage. The same problem occurs; that is, public money that should be going into increasing front-line services is going to be money that goes into the profits of the private consortiums that are building these privately financed hospitals. What do you think of a preamble that says, "We recognize our system of publicly funded health services," when you know the Liberals are going forward with private financing, and money that should go into those publicly funded services is going into the pockets of some of the consortium members?

Mr Parent: Obviously, I think that's misleading the people of Ontario. Even during their campaign they campaigned very hard, and the voters, as we say in our brief, voted against that type of health care you're talking about. Somehow, the Liberals were saying at the time that they were going to prohibit it. I think that has to be lived up to. There's no way we should have our publicly funded money going into making someone rich.

Again, in our brief we alluded to it. You look at other jurisdictions that have experienced the whole question of these P3 models and they haven't worked. In fact, the proof is in the pudding there that the actual cost increased as a result of going to these types of models.

So why would the Liberal government even entertain any thought process of doing it and not go in, as their pre-election campaigning said they were going to, and stop the three that were already on the radar screen by the previous government to go into that type of partnership, put a stop to it immediately and not look at six or seven more, whatever it is, to continue that thrust? At the same time they're saying they're against the two-tier privatization of the system in Ontario. They're speaking out of both sides of their mouths, in our opinion.

Ms Martel: If you look at the private MRIs, there was a great report done out of Alberta looking at the private MRIs there, which also clearly showed how much more they cost in relation to the MRIs and CAT scans that were operating in the publicly funded, publicly administered hospital system. Again, the Liberals said they were going to shut down these clinics, and they are not shut down. I heard the minister say on Monday, "We're not going to shut them down now; we can't at this point because people need the service." Maybe they should do what they promised, which was to move that technology into publicly funded hospitals so that people could get the service there. Again public money is going into the profits of the operators of the for-profit MRI clinics. What does that do when you have an alleged shortage of funds for health care? Does that make any sense?

Mr Parent: Not any sense at all. We in this community fought and campaigned very hard and rigorously to have our first MRI put into our Hôtel-Dieu Grace Hospital site, only to find out that it went there, but the problem was that the government of the day did not have the funding to keep it on a 24-hour basis to meet the needs of this community. Remember, we only had the one particular MRI, which was absolutely ludicrous. So here at 4 o'clock, 5 o'clock or 6 o'clock, that MRI would shut down because they had no funding for the actual staff to provide the programming.

I've said it publicly before and I'll continue to say it: They had a Together in Caring Campaign on this whole question of turning our hospitals from five acute to three acute. I said at that time, as labour council president, "We're not going to be there. We're not there until we get a commitment out of the government." Any government that sits in the province of Ontario has to commit that the proper funding will be there. It does no good to have nice entrances, it does no good to have shiny walls if you don't have the money to provide the programs for the services that meet the needs in this community. I'm telling you that that's what we don't have. We don't have the money to provide the services, to provide the front-line staff to meet the needs in this community. That's what's so wrong about some of the decisions that have been made on our health care system in our community. I think this community deserves an absolute, unequivocal apology from the government, all governments, both past and current, on what they did to this community. I think it was a tragedy; I think what they've done was terrible. Even the funding formula—

The Chair: Mr Parent, you're a little over your time. Thank you.

Mr Parent: —is not being properly administered in this community. We're underfunded, and someone has to look at it.

The Chair: Thank you. We still have some more questions. You'll have time to continue, just with somebody else.

Ms Di Cocco, from the government side.

Ms Di Cocco: Thank you for your presentation, both of you; they were both very passionate. You obviously have had a great deal of experience in the health care field.

First of all, I can't agree with you more that we should not be using public dollars to line anybody's pockets. I can say this—now, I know there is this constant rhetoric that we are for private hospitals. We are not. I can assure you that we're committed to a health care system that's publicly owned, that's publicly controlled and that's publicly funded. I don't know how much more clearly we can relay that. I know there are a lot of other agendas out there that try to suggest that's not the case. I would not be serving as a representative from my area if I didn't believe that was the case. That's what we believe in. We have heard even the economic argument that, no, it isn't cost-effective to have privatization in many cases. It isn't effective.

By the way, there are definitely tremendous challenges. I heard Mr Pellerito, I believe, saying, "We've been consulted to death." This bill, the intent of it, is so we can reaffirm our commitment to medicare. It is also about dealing with accountability, because yes, there is a funding issue that's there, but it's also the accountability mechanism that we have to look at, how the money is being spent. That's very important as well, as you know; I don't have to tell you that.

I heard Mr Pellerito talk about his dad, and I understand when we personally face challenges in the health care system. As government, all we want to do is to make it better. This process, the process of really listening—this is a bill that's been brought forward at first reading so we can hear the experts or people who are out there say, "Look, this is what's really gone wrong here. This is what's not working. This is what we'd like to see changed."

I can say to you that when it comes to the concern you have about regulations, which was my concern when I was in opposition, a huge concern, in the amendments we're going to be bringing forward there are going to be a lot fewer regulations we're going to be dealing with, and the minister is going to consider some of those regulations for public hearings.

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Our intent is to deal with the tremendous structural deficit we have in this province, that you've both described better than I could, a structural deficit over many, many years of taking out and taking out, and things don't work the way they should be working.

What we want to do with this bill, in getting input at first reading, is get the best possible legislation so the concerns raised by the interpretations—this is only a proposed bill—that you have provided, how you see it, will better help the government to draft a bill that is there to serve the public or that is in the public interest.

Mr Parent: I guess I have one question that I'd like to put to you.

The Chair: It'll have to be in about 10 seconds.

Mr Parent: What changed from pre-election to now on the P3s? Why is this government persisting in going forward on the P3s now and not—

Ms Di Cocco: But we're not.

Ms Martel: Private financing.

Ms Di Cocco: But it's publicly owned. It's the ownership; it's publicly owned.

Interjections.

The Chair: Order.

Ms Di Cocco: It's publicly owned, publicly run.

Interjections.

The Chair: Order.

Ms Di Cocco: You have a vested—

The Chair: Order. You've been so good everywhere else. Just in Windsor everybody starts acting out. What is it? Thank you very much for coming today. You've caused a little excitement, and maybe that's good for us.

Mr Pellerito: We've done a lot in this community. That's why you ought to be listening to us.

The Chair: We are. We will be.

JAN KEMPE

The Chair: Could I call forward Jan Kempe. Mr Kempe, make yourself comfortable. I understand you're speaking on your own behalf today, is that right?

Dr Jan Kempe: I am indeed. I'm speaking on my own behalf, on my patients' behalf and on behalf of the chiropractors.

The Chair: So it's Dr Jan Kempe then.

Dr Kempe: I'm Jan Kempe, chiropractor. Dr Jan Kempe.

The Chair: Very good. You've got 30 minutes. You can use that any way you like. At the end of your presentation, we'll split the remaining time up among the three parties. The floor is yours.

Dr Kempe: My name is Jan Kempe. I'm a practising chiropractor in the city of Windsor for some 38 years. I'm pleased to make this submission in support of Bill 8, the Commitment to the Future of Medicare Act, at least insofar as I understand it. I understand that Bill 8 is intended to demonstrate Ontario's commitment to medicare, which in Ontario is the OHIP system.

When I began my practice in 1966, it was a rare month when I received a referral from a physician. It was unusual for a person to attend a chiropractor. Some 3% did, at most, in any given year. Now 12% to 14% of Ontarians visit a chiropractor every year, and some 40% have in the last five years. The reason is that many physicians now refer patients to chiropractors. Over 85% of my practice is based on direct referral by the medical professions. They do so because chiropractic care is safe care, it is effective care and it's inexpensive care. All of those clients referred by their physicians, family doctors and specialists present with musculoskeletal pain; many are elderly. Chiropractors share in the care of these clients in collaboration with their physicians. This is coordination of care, and this is good medicine.

Coordinated, collaborative care is good health care for patients. Whether we speak of the unfortunate individual who can't stand erect because of back pain or who suffers excruciating headaches due to some neck dysfunction following trauma, in any event, the intervention of a well-trained professional is paramount. The alternative is long waits for specialists, unwarranted tests and unneeded medication.

Good health care is appropriate intervention by appropriate professionals. This allows a physician to focus on those patients who need her expertise and allows me to focus on those who need my expertise. In this age of shortages, it would indeed seem appropriate to have the physicians focus on the things they know best.

As a senior practitioner of chiropractic, I feel I'm well past the point where I should have to justify the efficacy of my care. I think the WSIB's new evidence-based program of care for back pain provides for the treatment of patients in the manner in which chiropractors, including myself, have been practising for years, that being early return to activities, spinal manipulation, exercises and education.

I provide timely, cost-effective interventions. In my absence or in the absence of others like me, who takes the time to explain, counsel and demonstrate? Who is better trained to prescribe the exercises and the needed lifestyle changes? Who is better placed to restore function to a joint? No one duplicates the services I provide.

As noted earlier, I treat many elderly. Most present with few things other than pain syndromes, and for them, health care is musculoskeletal care. Withdrawal of funded services would lead to lack of mobility, loss of independence, increased use of pain medication and increased discomfort. Support in the form of effective chiropractic care is their path to independence and comfort. This act ignores that type of health care.

Many individuals cannot access chiropractic care because of lack of funding. There are few alternatives. I can tell you unequivocally that cost is the major barrier to appropriate musculoskeletal care that my patients face in this community. There is limited OHIP funding, which amounts to about 30% of a visit. Back in 1970, when OHIP started, it was 80% to 85% of a visit.

I understand this act does not prohibit copayment, because with only partial payment, this is not understood to be extra-billing. However, in the absence of funding, which this act facilitates, those individuals who can't afford appropriate musculoskeletal care will seek an option which costs them nothing but which costs the province much more. They may attend a clinic, visit the ER or take medication paid for by the Ontario drug benefit program, or there may simply be lost productivity as they heal more slowly or incompletely.

I refer specifically to section 10. In this country, the third most frequent reason for attending a health practitioner is musculoskeletal pain. Nevertheless, conspicuous by their absence in section 10 of the bill, which establishes that OHIP fees will be reached by agreement with associations, is any mention of those professions most closely associated with the treatment of musculoskeletal pain, specifically chiropractors and physiotherapists.

Although the act provides for other associations, it is apparent that the absence of specific mention of chiropractic and similar professions is an indication of this government's lack of commitment to that component of the Ontario health care system. I'll leave the other professions to speak for themselves.

Section 10 refers only to physicians, dentists and optometrists. It specifically ignores those most qualified to treat the fully one third of patients who present with pain syndromes: chiropractors and other similar practitioners.

I agree that medicare must be preserved and that the future can only be assured with perfect planning, but that planning should include the other health professions like chiropractic, which provides effective, evidence-based care, which are good value, specifically low-cost, have a large impact on patients' speedy return to normal activities, which are valued by patients and which are not just add-on costs but which take pressure off other parts of the system.

With respect to accountability, this act purports to increase accountability by requiring anyone receiving funding to enter into an accountability agreement. In the light of only partial funding, I've long been accountable to those who matter most, and those are my patients. Chiropractors, like other publicly funded health service providers, have always been accountable. Greater accountability should be welcomed by everyone, and I and other chiropractors don't fear it. The colleges already have standards of practice and peer review programs which maintain high professional standards, and I'm ready to be held accountable not only for my patient outcomes but also for the value received for the OHIP dollar.

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With respect to accessibility, this act has specific provisions for eliminating barriers to access, including financial barriers, specifically the elimination of extra-billing, direct billing and block fees. I reiterate that one of the barriers my patients face is the barrier that exists because of costs, and there are no alternatives. MSK care is not very noticeable; it's dramatic to no one but the individual who is returned to mobility, function and work. Nevertheless, there remain many individuals who can't access chiropractors and physiotherapists and their services because of lack of funding. This act ignores the fact and enables its perpetuation.

I'd submit that the future of medicare in this province requires a careful look at the big picture. Making the best use of human and other resources we have is paramount.

I conclude by saying that this act as written, particularly section 10, which talks about medical, dental and optometric services, continues to perpetuate the dismissal of other valuable services, including chiropractors, nurse practitioners, pharmacists and physiotherapists. It perpetuates the concept of funding silos and the dampening effect on efforts to save costs by providing the most appropriate and cost-effective care. It impedes our ability to utilize the most effective human resources in specific instances. It continues to rely on the medical practitioner to the exclusion of all others, despite, in this city, shrinking manpower, expensive tests and long waits. I consider chiropractic an integral part of our health care system, and I would ask you to look carefully at section 10.

Thank you very much. I'd be happy to answer any questions.

The Vice-Chair (Mr Jim Brownell): Thank you, Dr Kempe. We have about 21 minutes, so we'll split that: seven minutes each. From the opposition side, Ms Martel.

Ms Martel: Thank you for coming here today. Some of your colleagues came to see us in Sudbury, which is my hometown, and raised similar concerns.

One of the suggestions I made with respect to section 10 was that we could do one of two things: either delete from this section any reference to any associations so no one is excluded, or add all the regulated health professions and list them in that particular section, so it

would be clear that the government may enter into agreements with all the regulated health professions, because all, in some way, receive some funding. For some it's partial—and I appreciate that in your case—and for others it's a fuller amount.

I'm not sure what the government will come back with in terms of a change to that section. I'm not interested in a bill that would exclude any of the regulated health professions or undermine or lessen the contribution they have to make to the health care system, so whichever of those two options works is an option I'm interested in. But as it appears now, it certainly gives everybody the impression that chiropractors are excluded, dental hygienists are excluded and all the other broad categories of health care providers regulated under RHPA are also excluded. That can't stand the way it is.

I hope it will give you some comfort that in fact there was a recognition in Sudbury that this section cannot stand the way it currently stands. It would leave everybody with the impression that the government doesn't want to negotiate with you or doesn't appreciate the skills and competence that chiropractors can bring to the health care system. I hope that will give you some comfort.

Dr Kempe: It gives me some comfort. I would fear that if you don't mention all the professions, it would then leave the door open to negotiate with none of the professions or whichever professions the government in power at that time would choose. Certainly I'd much prefer that they list the regulated health professions.

Ms Martel: So the 21 or 22 are listed in part I, and then, in part II, the associations are listed as well, because we'd have to do it in both sections. I appreciate that recommendation.

In light of that, and maybe it's because of what currently appears in section 10, on page 4, in the top paragraph, you said, "However, in the absence of all funding, which this act facilitates, those individuals who can't afford appropriate MSK care will seek an option which costs them nothing but which costs the province much more." Was that a reference to seeing that you were not included and assuming there were not going to be any more funding negotiations between yourself and the government?

Dr Kempe: If we're not included, the option is there not to negotiate with us at all or to drop it out or to terminate funding for us and the physios and any other musculoskeletal care professionals and leave them with nothing.

Ms Martel: That's a legitimate concern if you look at the current wording of the bill. That's exactly the inference you could draw. But none of us is going to have that happen. I don't disagree that the current funding you're receiving is much different from the 1970s; it's much less, and that does put additional burdens on people who may not be able to afford their copayment. But I don't think any of us had the impression from the minister that what he was talking about was eliminating any portion of funding at all to chiropractors or to the other regulated health professions. I don't think that's where he was going, and none of us would support that.

The Chair: We'll move to the government side.

Ms Smith: I'd like to thank you very much for coming to speak to us this morning. It's important that we get input from the various groups and stakeholders and individual practitioners, and we really appreciate your participation in this process. My colleague will speak a bit more about the process, but I just wanted to address a couple of your concerns, specifically with respect to section 10.

Section 10 of this bill was drafted as it was set out in the health care accountability act, which was passed in 1986. It's an exact duplication of that provision, which is what you and other regulated health professionals have been living under. So there was no intention of leaving out specific health care providers; it was just a tracking of the language that previously existed.

Subsection (3) of that particular section allows the minister to enter into agreements under subsection (1) with specified groups or organizations other than the associations mentioned in subsection (2). It does allow the minister to continue, as he or she has in the past, to enter into agreements with regulated health professionals.

I don't think you should take this as any kind of slight. It was a tracking of previous language. It is not in any way an indication from this government that we do not intend to continue, as governments have in the past, to deal with all regulated health professionals, including chiropractors. I hope that goes some way to calm your fears.

It may be as a result of Ms Martel and I spending too much time together this past week that we both underlined the exact same sentence on page 4, the top paragraph. She addressed it, and I think I have as well, in just outlining to you where section 10 came from and the fact that subsection (3) does allow for agreements.

As to the accountability agreements, which you seem concerned about, the minister stated in his opening statement on Monday that the accountability agreements we foresee through this legislation will be between hospitals, CCACs, long-term-care facilities and other independent health institutions, and not between particular physicians or health practitioners and the government. That might be what you were referencing on the bottom of page 5 and the top of page 6. That is not the intent of this legislation, and the amendments we bring forward will address that particular concern.

I think at this time I'll let my colleague, Ms Di Cocco, have a few more comments and questions.

Ms Di Cocco: Thank you very much. The intent of this committee in having this bill here at first reading is that it's a proposed bill, and your input, sir, is very important. You make a really good remark in your submission about the big picture, that "making the best use of human and other resources we have is paramount." I think that's the crux of the matter. Many times in this huge monolith of health care—you provide examples of how in your profession you provide a good service for the dollars spent and the accountability mechanisms you have. For us to have an official submission from you

provides the government with on-the-ground input, some of your opinions. Again, I thank you for that. If you could even make any other comments in regard to the accountability mechanism, it's a huge financial consideration in this province and it seems the accountability mechanisms are truly important. You've outlined how you've met those obligations in your profession, so if you have anything else to say about that, I'd be glad to hear it.

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Dr Kempe: Are you asking me to comment on accountability as it refers to practitioners?

Ms Di Cocco: In a large context.

Dr Kempe: Are you asking about corporations and hospitals and things like that?

Ms Di Cocco: And practitioners, if that's your—

Dr Kempe: As a professional, I'm more comfortable speaking about practitioners. As an individual, I suppose I could address anything.

Certainly all practitioners who bill OHIP have multiple accountability measures to which they have to adhere. That includes reviews by OHIP and audits. There are letters sent to my patients. Every couple of years, patients start calling, saying, "I got this letter from OHIP about whether or not I was really in your office." I say, "Well, tell them." So there's that type of thing. There's the chiropractic review committee, and there's the CCO. As practitioners, we feel there's a whole bunch of loops we have to jump through. Certainly, I don't know of anybody who's ripping off the system or billing in instances when services are not provided.

Ms Di Cocco: When it comes to this process of actually asking for input before the bill is at second reading—this is first reading, meaning that the whole process is about modifying this bill so we can catch issues that are out there that we want to modify and draft a better bill—do you have any comments about that process?

Dr Kempe: I can't fault the process. I have concerns about section 10, and the reason I'm concerned is that this profession and a number of ancillary professions including the physiotherapists, I know for sure, and I believe optometrists and one other group, reached agreements with the government before the last election. Those agreements have disappeared somewhere. The current government is not aware of the agreements, and that scares us. It scares the physios, and it scares a number of other professions.

The Chair: We'll go to the official opposition.

Mr Hudak: Thank you for your presentation. It sounds like you've reached a sympathetic ear with all three parties with respect to section 10. I understand the Minister of Health is delivering amendments at one o'clock or so today. Hopefully that will be included in those amendments and we can clear up any kind of misunderstanding about the government's intentions. We look forward to those amendments.

I have a couple of questions for you. You mentioned that about 30% is funded through OHIP and the rest is

through either the insurance company or the individual's pocket and that sort of thing. How do you set the total fee?

Dr Kempe: That's an individual thing. It's illegal to collaborate on setting fees.

Mr Hudak: So it's set by the market; it's not set by the government or any institution?

Dr Kempe: Yes, it's set by market. The members of the CAW in this particular locale are very lucky in that their union probably looks after them much better than most unions. The people in Windsor do a little better with respect to funding than most other people in Ontario, but the 40% to 50% who don't have extended health care either don't come or come for the 15 visits that OHIP partially funds, or we're just nice people and treat them for free.

Mr Hudak: Is there any reason for concern, if accountability agreements are put upon chiropractors and such, that you'll lose the ability to set the fee without getting subsequent government funding to close that gap?

Dr Kempe: I always have fear when it comes to government funding. As far as accountability is concerned, if the accountability is linked to fee-for-service, then I would have some concerns. But as I stated, I'm not afraid to be accountable as far as value for service provided is concerned in my practice or in any other matter as far as accountability is concerned.

Mr Hudak: Maybe you could describe a bit the mechanisms that currently exist for your profession through the college of chiropractors for ensuring you do have accountability in training standards.

Dr Kempe: There are a number of mechanisms. There's a long-standing one that if you use radiographic examinations or take X-rays in your office, then every so often, about once a year, you have to send in copies of your X-rays and your X-ray reports to see that they meet quality standards. As it is now, one fifth of all chiropractors—so all chiropractors at least every five years—receive an audit in their offices by someone appointed by the CCO who reviews all the files and makes sure the practitioner is keeping proper documentation and that there are indications for the continuation of care and people are not being brought in just to generate finances.

Mr Hudak: The last question I have, and I think it's important, is with respect to the point you made in a general sense about how the fees are and that the fees have not changed in some time. Were any commitments made to you by the government, either when they were campaigning or in opposition, as to how they were going to address particular issues of importance to chiropractors?

Dr Kempe: I'm not aware that there were agreements between any party and ourselves during the campaign.

Mr Hudak: No campaign promises or commitments, either locally or provincially?

Dr Kempe: I'm not aware of any.

Interjection: Nice try.

Mr Hudak: It's always worth fishing. It's worth asking. We believe you should keep your campaign pro-

mises. If you say something during the campaign, you should keep it, and these guys don't. I thought I'd see if there was one here that I could throw back at them, but I'll have to keep looking.

Dr Kempe: If I had something on them, I certainly would have brought it up.

Mr Hudak: There you go. Good for you. Thank you, Dr Kempe.

The Chair: On that note, thank you for coming forward today. We appreciate it.

TEEN HEALTH CENTRE

The Chair: I call forward the Teen Health Centre, represented by Sheila Gordon, who is the executive director, and Dean P. La Bute, president, board of directors.

You have 30 minutes to use as you see fit. Any time remaining at the end of the presentation will be split among the three parties, and this time the party that will go first is the Liberals. The floor is yours.

Mr Dean La Bute: Thank you. My name is Dean P. La Bute. I'm president of the board of directors of the Teen Health Centre. I'm accompanied today by Sheila Gordon, our executive director. Ms Gordon will make the formal presentation of the position of the Teen Health Centre as it applies to Bill 8.

I would like to say as an opening comment that you will find we have documented in our submission that the model of the community health centre has its basis founded in the 20th century. You will find, as ratified by the government of Ontario in this report released at the end of June 2001, the Romanow commission report of 2002 and the position taken by Anne McLellan, the former federal Minister of Health, that the CHC model is the model for the 21st century for the delivery of primary health care in Ontario.

You will find that we have documented it is effective, efficient and equitable in the distribution and delivery of community primary health care services to all citizens. It has that potential. We will call upon you, the government, and the opposition members to recognize this established and documented fact and look favourably on the model we are presenting to you today for reaffirmation and confirmation that this is the way to go in the 21st century for the delivery of primary health care in Ontario.

At this time, I'd like to call upon Ms Gordon to formally present our report. Following the presentation, we'll be more than happy to answer any questions you may have.

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Ms Sheila Gordon: Let me start by giving you some insight into how the community health centre model actually fits with the provisions in Bill 8, the Commitment to the Future of Medicare Act, and also the recommendations, as Dean has pointed out, of the Romanow commission.

Community health centres are models of primary care, with multiple support services in place to ensure that

consumers receive the care they need, when they need it and where they need it. We believe that the government should continue to invest in primary health care and that community health centres are natural and worthy candidates for that investment. By investing in community health centres, the government will improve the province's health system and begin to deliver in a significant way on its commitment to expand primary health care across the province.

Community health centres have been in the forefront of primary health care for over 30 years. We support the government's commitment to the principles of accountability and accessibility, and we encourage this government to implement their plans for primary health care renewal across the province.

First, just a little bit about who we are in Windsor. Windsor and Essex county currently has two community health centres. One is the Sandwich Community Health Centre, which serves the geographic population on the west end of Windsor. Dean and I represent the Teen Health Centre, and we serve youth from the ages of 12 to 24 across Windsor and Essex county. We also serve the homeless population of all ages in the downtown Windsor core.

Today in Ontario there are 65 centres, of which 55 are community health centres and 10 are aboriginal health access centres. All these centres are community-based, non-profit organizations that provide high-quality, cost-effective primary health care services. But our centres don't stop there. I think one of the prime pieces that fits so well with primary health care is the focus we have on health promotion and illness prevention. As you know, prevention is going to save the government dollars in the health care system down the road.

In June 2001, the Ministry of Health and Long-Term Care completed a strategic review of community health centre programs. The key findings showed that:

- (1) We exhibit desired primary care reform features.
- (2) We are accountable through community governance, service agreements with the ministry and accreditation.

(3) We deliver on ministry goals and strategies.

(4) We have a strategic role to play in primary health care, particularly with serving populations that face access barriers to the system. Certainly, community health centres are one way to meet the need of underserved areas such as Windsor, which is significantly underserved.

In his 2002 report, Mr Romanow identified that the community health centre model of primary care was found to be an effective, efficient and equitable form. As Dean has already said, Anne McLellan has acknowledged our model as an effective one for primary health care delivery.

The Teen Health Centre applauds the approach the government is taking toward managing the health care system. We support the call for accountability agreements between the ministry and health resource providers. We also applaud the establishment of the Ontario

Health Quality Council to provide advice to government on health system outcomes and access to health services. It's important to measure what is happening in the health care system, and these two avenues will hopefully do that.

In order to achieve these outcomes, we need the support of shifting health resources to communities to deliver services closer to home. Spearheaded by local need and governed by local boards, health centres are quintessentially creatures of their communities. Primary health care is our number one priority and remains a top issue for the majority of people across the province.

Currently, the Teen Health Centre serves over 17,000 active clients through Windsor and Essex county. We have eight satellite offices throughout the county, with our main office in Windsor. In our last fiscal year, we had over 21,500 visits to the centre, to see physicians, nurses, dietitians, psychologists, social workers and counsellors. We also go into the community, primarily schools, and do health promotion activities and prevention services. Last year we saw over 5,500 youth through that method.

As you know, Windsor and Essex county is one of the most underserved areas in Ontario for family doctors. Many of the clients who use our services do not have family doctors and would rely, if it weren't for the services we provided, on walk-in clinics for health care. Some of our clients have a family physician but choose to use the Teen Health Centre because of the confidentiality and non-judgmental way in which we serve our clients.

We've recently received increased funding to provide an additional nurse practitioner. Those services are a cost-effective way to provide health care for our youth and homeless population. We certainly applaud the government for that as a step in the right direction.

Our medical department sees a large number of teens for sexual health reasons, yet the percentage of teen parents in Windsor is 26% higher than the provincial average, according to the health unit's health profile technical report of 2000. Increasing funding in our medical, counselling and health promotion areas will help us to reduce this number to at least the provincial average. This one area alone will help the provincial government reduce costs to health care and to the welfare system as well. Additional funding would allow us to serve 200 new clients a month, as well as providing our existing clients with increased access to physician, nursing and dietitian and counselling services.

Our current waiting lists for counselling services are approximately eight to 12 weeks. For a teen who has made the decision to stop using drugs and alcohol and turn their life around, this waiting period is far too long. For a client who is depressed, an eight-week waiting period can result in hospitalization.

The demand for Teen Health Centre staff to do presentations in high schools and elementary schools far exceeds our ability to provide this service. We need additional health promotion staff to meet those demands

and allow our clinical staff to remain in the centre to serve clients.

The committee may not be aware, but the salary budget lines of community health centres were frozen for over 10 years. Recently, the ministry reviewed and approved new salary scales for physicians, nurses and all the other staff we have, and it was measured in today's environment against other health care providers. The funding for the scales, however, was only provided at 60% of the ministry recommended rate because of funding shortfalls. We're not here to complain that we received increases; we're very grateful for that. However, it becomes a recruitment and retention issue when we're competing with other areas of the province or within the city. To compete with a hospital to try to hire a nurse practitioner—they're offering the top of the range, which is higher than the amount of our funding. So we're hoping that we can, through wise investment, help solve that problem.

The proposal submitted to the Ontario government by the Association of Ontario Health Centres in 2002 can provide assistance to the government in managing the health system and to patients who are trying to gain better care and better access. People go to hospital emergency rooms not because they want to but because they have no alternative; they cannot gain access to their family doctor because it's an after-hours time or the clinic has been closed. By funding our proposal, our community health centres are in a position to provide 24-hour access, seven days a week. So we can provide a natural alternative to hospital emergency rooms, which should improve patient flow in ERs and make sure hospital capacity is maintained for true emergencies.

One of the things we do at the Teen Health Centre is stay open until 8 o'clock two nights a week so that our clients can come after school or after their jobs and still have health care access to their primary health care provider. A number of other community health centres across the province are open three or four nights a week providing the same types of service, which again fits into the access issue addressed in Bill 8.

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Our wellness approach also encourages people to take better care of themselves, which in turn may prevent illness and result in fewer emergency room visits. Health promotion activities should be looked at as an investment in the future and a cost reduction down the road. The government is certainly correct; we would agree with their approach in expanding primary health care teams or groups across the province, but we would also urge you to consider that one size does not fit all, nor does one model, so we should look at a variety of models. We're not here today to say that the family physician should be outlawed. You shouldn't consider that; certainly, the system requires that. But you should consider an expansion of what we do.

We have a proven, cost-effective, measurable model that treats all of the individual's primary health needs. We also serve the hard-to-reach population groups that

can potentially drain hospital resources if care is not provided ahead of time or on time. The strategic review the ministry did notes that community health centres are one way to meet the needs of underserviced areas, and certainly in Windsor, the Sandwich Community Health Centre has been outstanding in that area, but they have a closed practice because they cannot take on any more clients with the number of practitioners they have.

We have a wellness philosophy and approach about making people well so they don't need to rely strictly on a treatment regime. We know this is a priority for the government, and we think we are an effective and successful strategy to achieve this goal.

In summary, the key points that I think community health centres can offer, and do offer currently, are that we feature a multidisciplinary team, we provide 24-hour access to coordinated services and our model of care is built on a broad understanding of the determinants of health. All providers in our system promote illness prevention and health promotion. Our centres have invested heavily in information technology and we can measure what we do and what we achieve. We have a high level of patient satisfaction. Our centres are community-based and reflect the health and service needs of the communities. We are accountable. We enter into service agreements with the ministry on an annual basis. We are governed and managed by local board members. We submit to an outside review through an independent accreditation process.

What we hope to accomplish is to reaffirm our presence and worth in today's health care system. Key health directions the government has identified as priorities are areas in which we have a proven track record of accomplishment. We support the direction taken in Bill 8 for access and accountability to all Ontarians. We know that investing in community health centres like the Teen Health Centre will result in an improved community health care system.

Those are my comments, if you have questions.

The Chair: Thank you, Ms Gordon and Mr La Bute. You've left us about 15 minutes, which would be five minutes for each of the parties. We'll start with the government side. I've got Mr Duguid and Mr Brownell.

Mr Duguid: I'll try to be as quick as I can to leave some time for Mr Brownell. I think, frankly, we couldn't agree more with a lot of what you've said in your presentation. It is an excellent presentation and, frankly, I'm going to keep it aside as we're going through our changes to the health care system. It's something to refer back to.

Mr La Bute in particular talked about the community health centres as being the future of our health care system, and again, I couldn't agree more with that. I think the government and all members around this table agree with that. It's a question of how you can move to that model from the very institutionalized model we have now.

You talked a little bit about shifting resources. My question to you—and it may be an unfair question

because it's a difficult one—is how the heck do we do that? We've known for 20 years that community-based health care is the superior model, but shifting those resources has been the difficulty. We've closed the beds in some cases, but we haven't got the resources out into the community to accommodate those changes. Do you have any comments on that?

Mr La Bute: I do have several comments. One, we have to renew our relationship with the federal government and have the federal government step up to the table and meet its obligations under its commitment to the future of medicare in this country. Through a collaboration between the provinces and the federal government, we would bring into the system the necessary funding to fund the system now and for the foreseeable future.

Separate and apart from that, I have been involved and have been in communication with many members of all three parties over the years and am of the understanding that there's considerable money in the system. It's the allocation of that money within the system, possibly the approach of an audit of the system—it's a systemic problem across the system that you are dealing with. It may be that we have enough money in the system and that it's the reallocation of those funds, with emphasis being placed upon prevention and primary health care, so the funds that are necessary for acute care will be there, and the beds in the hospitals will be available and not taken up by others.

Mr Duguid: My second question is, and I'm going to make it as brief as I can to try to save time, you serve the homeless population here in the Windsor area. One of the problems I've seen in urban areas has been that hospitals, in particular for the mentally ill but not just for the mentally ill, will provide a treatment or a service, but pretty soon they're out the door and back in the street, where there really is no opportunity to convalesce at all, in particular if it's a surgery or something like that, or even in the case of a mental illness. They'll get them back on their meds and within a few days they're back out on the street again, only to maybe have to be taken back to the hospital a week or two later. After a while, I think the social workers just grow tired of that circle of non-treatment and stop doing it.

Do you have any comments as to how community health centres might be able to contribute to helping us resolve that difficulty?

Ms Gordon: The system we have in place in Windsor is that we have a nurse practitioner who is located actually at the Salvation Army, and they have hostel and crash beds for homeless people. So she's there a couple of times a week and can do that sort of follow-up from an acute care incident and monitor meds or help them, work with them to ensure that they're staying on medication or following the protocols.

Again, we could absolutely use another full-time nurse practitioner in that system, because we move her between about four different satellites. The homeless population is not a population to whom you can say, "I'm here."

Everybody come and see me." You have to go to where they congregate and where they feel safe and comfortable, and trust in that population is a big issue. It's a difficult population to put in a healthy situation, just because of the nature of the lifestyle and the extreme poverty. But definitely having a nurse practitioner available to them where they reside or where they go for the warm lunch has been very beneficial.

Mr Duguid: Thank you. I hope there's time for Mr Brownell.

Mr Jim Brownell (Stormont-Dundas-Charlottenburgh): It's more of a comment, but I might have a question.

I just want to say how exciting it is to have you here at the table and to hear community health centres being part of the talk that we're into now, part of the dialogue. I believe that is Minister Smitherman's big interest, to have this as part of primary care.

Before I ever got into this—I'm one of the rookies—in 2003, it was exciting to see when the leader of the official opposition came to my riding on two occasions to see how a francophone health care centre was working in my constituency, where we have a large francophone population. It is the minister's wish, and he's very keen on this, to have it as part of primary care delivery.

This morning we've had a few comments about Windsor being part of underserviced areas, and I think it's very important to have these centres in these underserviced areas. So it's really exciting to see you here. I wanted to say that as somebody who has been very much a part of health care centre work in my community. Thank you for being here.

The Chair: Let's go now to the official opposition.

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Mr Hudak: Thank you both for your presentation, certainly the ideas you bring forward in terms of reinforcing the multidisciplinary approaches to health care and community-based health care.

There's a question I had for you. One thing we haven't talked too much about yet today are the privacy issues inherent in Bill 8, very serious privacy issues. In fact, I think the reaction was so strong initially when the bill was introduced, it provoked the minister to bring forward Bill 31 to deal with access to personal health care information. Particularly in the teen health centre, you would deal with some very sensitive issues, with STDs, teen pregnancy and things like that that parents may even not know about in some circumstances.

Maybe just for the committee's records, could you describe some of the sensitivities that any good government policy would have around personal health care information? Under what circumstances would it be appropriate for that information to go to the Ministry of Health or the minister himself or the health quality council, all of which are allowed in certain circumstances under different provisions of this bill?

Ms Gordon: I just returned from meetings in Ottawa, where all the executive directors of community health centres were meeting with the ministry. In primary care

alignment, the biggest issue, particularly for youth centres and those centres that serve a homeless population, is the issue of enrolment that the ministry is taking us to. We've identified clearly to them that there are clients we have who would be unenrollable in that alignment issue that the government is looking at.

For example, if we had a 22-year-old who wanted to come and we would enrol her as a client with us, that information would forward to the Ministry of Health. She would make that choice. I say "she," because 80% of our clients are female. We might have a 16-year-old who's at the teen health centre for birth control and doesn't want her parents to know. If that information moved forward and the parents had enrolled that 16-year-old with another health care provider, our main concern is that that information would get back to the family doctor whom the whole family sees and some confidentiality may be breached.

That is an issue. We're working with the ministry to look at ways in which we can avoid that. Clearly, at our centre, our staff is unanimous in saying, "We won't enrol them, because we cannot risk that a confidentiality would be breached." We wouldn't have anybody coming to our centre if that got out on the street. They come to us because of confidentiality.

Mr La Bute: That's a bedrock policy within our organization and throughout the association. Confidentiality, as documented in our submission, and a non-judgmental approach to dealing with our clients is paramount to the success and credibility of our organization.

Mr Hudak: I appreciate the point. I'd push it a bit farther, because I think it is very important. We want to make sure that, through the amendment process, Bill 31, which will have some rules in place in terms of disclosure of information—to whom and what types of information, and when you anonymize the information, for example—would take precedence over anything in this bill. In fact, we're going to make sure that aspects of this bill that could compel information to go to the health minister would only occur in the most limited of circumstances, subject to good privacy practices.

For the benefit of the committee, are there good principles of privacy practice that you could recommend to us or sources for those privacy policies, in terms of what type of information should be allowed to go forward, whether it's to parents, to the minister, to the Ministry of Health, that sort of thing?

Ms Gordon: Currently, with the system we're under, on a regular basis we do send in to the ministry a listing of the services we've provided and data about the individual. Rather than using an OHIP number, a health card number, we use an identifier that's a made-up computer number, so there's no way to link the information. Clearly the ministry needs information about the type of services—if we're going to measure outcomes, they need to know what we're doing—but we need to do it in a way that's confidential so you can't link that information with a specific person.

Just going back to what I said before, the ministry appears to be open to our not enrolling clients for con-

fidentiality issues. There are also issues around enrolment for people with serious mental illnesses, homeless people or people in poverty who have been subject to terrorism or persecution in their home country.

Ms Martel: I want to thank the two of you for being here. I want to preface my questions by saying I'm a huge fan of CCA—CHCs. Not CCACs; I'm not a fan of those. I'm a huge fan of CHCs.

Mr La Bute: There's a big difference, Ms Martel.

Ms Martel: You've got that right, in terms of elected boards versus non-elected boards and a whole bunch of other things.

I'm pleased I was part of a government that was probably responsible for 21 of those 55 that are established now, and all the 10 aboriginal community health centres, which were established under the aboriginal wellness and healing policy. So I support a full extension and was glad we got a francophone community health centre in our own community through that period of time.

The bill says in the preamble, "Recognize that access to primary health care is a cornerstone of an effective health system." Without raining on anybody's parade, where does the bill commit to establishing new CHCs in Ontario? It's great that the preamble has that as a policy statement, but the bill is silent on when the government's going to move on this important matter.

Mr La Bute: By incorporating that in the bill, we'd be restricting its application. Now it's wide open, and it's open for the opposition parties and the government to work in collaboration to see to it that that is carried out. We're concerned about the issue of accessibility and accountability, and we've documented how we address those issues.

Please keep in mind, ladies and gentlemen, that Canada is unique in the world; 34% of our population is baby boomers. The first wave of baby boomers turned 55 in 2001. As we move along that continuum of life, we want to be able to have accessible primary health care to meet our needs. We have been privileged in this country, we in particular as baby boomers. We've always had our way, and we continue to expect to have our way. If the government of the day doesn't provide it, then maybe a new government will.

Ms Martel: My concern is that if it was a priority to move on this—and I think it should be, because Romanow was very clear that we needed to move on primary care reform—then somewhere in this bill, which talks about medicare and which was introduced on the first anniversary of the release of Romanow, you'd think there would be some acknowledgement of the government's commitment to move and that there would be some provisions somewhere in here that said, "We are going to recognize CHCs as an appropriate model, as one of perhaps several models, and we are going to move on this." My concern is that we're moving forward with a bill that talks about medicare but there's nothing in it that enhances the services people need. I'm not sure when we're going to see that.

Mr La Bute: Ms Martel, once again, you're quite apprised of the political process. When you go through

the committee readings and the line-by-line review, that's when the public has spoken; the government will listen, and the opposition parties are obligated to see to it that the government reflects in its legislation the wishes of the people who elected the government of the day.

Ms Martel: And we hope we will see some amendments that speak specifically to CHCs. It would be very important.

Let me ask you what your budget is. You have a full CHC, so is your operating budget in the order of \$3 million to \$4 million?

Ms Gordon: Our budget from the ministry is about \$2 million, and then we have other funding sources, so our total budget is around \$3 million.

Ms Martel: Operating. Let me ask you this, because there was certainly a suggestion raised of, where is the money going to come from? The dilemma I see is that primary care reform has focused in the last couple of years almost entirely on family health networks. I've had some serious concerns about the family health network strategy, because I don't think it incorporates the many health care providers who should be brought into the health care system in order to use their scope of practice and their expertise to provide care. I think some of that money that has been sitting in the Ontario Family Health Network unspent could easily be diverted to support new community health centres. I look forward to the Minister of Health making that statement in a public way so CHCs would know, then, that there is going to be some funding for them and some way to access some of this money.

My concern also, though, has to do with what I think the Liberal promise was with respect to primary care. They talked about family health teams. If I remember the commitment clearly—and someone will correct me if I'm wrong—it was \$150 million for 150 new family health teams, which would be about \$1 million per family health team. That's not going to buy us a community health centre, is it?

Ms Gordon: Probably not, at a million dollars per team. I guess it's just how you would take the money and divide it up. But certainly there are smaller centres. We are considered to be in the larger group. We sort of categorize ourselves into small and large, so we would be considered larger.

But you're right. It depends on the population you want to serve, your location, and really it comes down to the staffing issue, because that's the largest component of the budget. You're going to have two or three doctors, and then you get into on-call issues and those sorts of things. You need a minimum number of doctors and nurse practitioners to cover on-call and provide the primary care services. You need the support services, the counselling, to go with that, because the doctor then is not going to spend physician time doing counselling. The doctor can do the medical assessment, decision-making, treatment plan, and then refer them on to a counsellor, but if they can't see the counsellor for 12 weeks and it's a drug addiction issue, they are going to spend physician time doing drug addiction counselling.

The Chair: Mr La Bute and Ms Gordon, as our last delegation of the morning, thank you for coming. We certainly welcomed your input.

Ms Smith: Chair, I'd like to inform the committee that I will now be filing with the Chair a memo from the Minister of Health and Long-Term Care, George Smitherman, that includes an outline of the proposed amendments that we intend to table during clause-by-clause. I have copies for everyone. I just want to remind my colleagues that this is a framework; it doesn't address every clause in the bill. It does address some of the issues and concerns that we've been hearing about this week. We continue to look forward to working with you on this living document. We look forward to the next four and a half days of hearings. We expect to hear much more discussion. These are provided for the benefit of the committee at the request of the opposition members, and we continue to look forward to discussing specific clause-by-clause language on March 9. I will present this to the Chair.

The Chair: And you have a copy for everybody?

Ms Smith: I do.

The Chair: Wonderful. Thank you.

Mr Klees: Chair, if I could speak to this, it's my recollection, and I may be wrong here, that when the minister undertook to distribute this, there were presenters at that meeting who also asked that they be included in that distribution. I was just wondering if that—

The Chair: We can research that. If that obligation was made, I'm sure it will be kept.

A little bit of housekeeping. Checkout is 12:30 if you haven't checked out. Lunch for the committee members and staff is in the Windsor Room. If the subcommittee members could just stay behind for a very short period of time, we have a brief issue to discuss. The room will not be locked, but there will be somebody here at all times.

The committee recessed from 1224 to 1334.

**ONTARIO ASSOCIATION
OF SOCIAL WORKERS,
SOUTHWESTERN BRANCH**

The Chair: Can we come back to order. Our next delegation this afternoon is from the Ontario Association of Social Workers, Southwestern branch. The person who will be addressing us today is Mary Kaye Lucier. Ms Lucier, if you would come forward, have a seat at the end of the table and make yourself comfortable, I'll briefly explain the rules to you. You've got 30 minutes. You can use that 30 minutes any way you see fit. At the conclusion of your presentation we'll be asking the three parties to ask questions of you from the government side, the official opposition and the third party in rotation. Other than that, it's 1:36 and the floor is yours.

Ms Mary Kaye Lucier: I'd like to thank the standing committee for coming to Windsor and hearing all of our input. I hope you enjoy your stay here, with that beautiful view out there as well.

The Ontario Association of Social Workers is a bilingual membership association, incorporated in 1964, with over 3,000 members to date. Practising members are social workers with university degrees in social work at the doctoral, master's and baccalaureate levels.

The OASW is one of 11 provincial-territorial associations of social workers which belong to the Canadian Association of Social Workers, which is, in turn, a member of the 76-nation International Federation of Social Workers.

The OASW has 15 local branches across Ontario. Our association embodies the social work profession's commitment to a civil and equitable society by engaging in social action related to vulnerable, disadvantaged populations and taking positions on important issues. Today's brief is prepared by the chair of the southwestern branch, encompassing Chatham-Kent and Windsor-Essex.

Bill 8 is titled the Commitment to the Future of Medicare Act. It was introduced in the autumn as the fulfillment of the Liberal Party's promise to enshrine the Canada Health Act in Ontario law, to create a health quality council to monitor and provide accountability, and to prohibit two-tier health care. As it stands, the bill does not further the implementation of the principles of the Canada Health Act, nor does it provide improved democracy, transparency or accountability. It does not prohibit the further erosion of the scope of medicare or the increasing problems of privatization, profit-taking and two-tiering for those services that have been delisted. Further, it gives the Minister of Health sweeping powers without clear intent or democratic control.

This brief is an attempt to highlight some local examples from Windsor-Essex and Chatham-Kent of how the current medicare system is failing persons with a mental illness specifically, and the need for improved and enhanced services for mental health through this legislation.

(1) Rebuild a commitment to the universality, comprehensiveness and accountability of medicare.

The population of Windsor-Essex and Chatham-Kent resembles that of the provincial average regarding demographics. However, a distinct trend is evident in that the geographical location houses a greater population of young people in Windsor-Essex and a greater population of seniors in Chatham-Kent compared to the provincial average. In addition, Windsor-Essex has experienced a growth in population between 1996 and 2001. Overall, the projected increase in population is well above the provincial average, especially for adults.

The percentage of poor children living in female, lone-parent families in Windsor has risen by 89% since 1996. There are 75,975 immigrants in Windsor, an increase of over 10,000 between 1996 and 2001. Future projections speculate that if the economic climate remains steady in this area, the numbers will again increase. The number of immigrant youth residing in Windsor is 4,390, representing 11% of the youth population.

The citizens of Windsor-Essex and Chatham-Kent are suffering the effects of our debilitated health system

compared to the rest of the province. For those with a mental illness, these realities are life-threatening.

Most of the Windsor-Essex and Chatham-Kent mental health care system has not seen new money come in since 1989. It has been seriously eroded by years of cuts. The practice of delisting has caused pressure on agencies to find ways to assist clients who are the most needy in accessing required services. For Windsor-Essex and Chatham-Kent, a designated underserviced area, this has meant increased waiting lists for children's mental health and adults diagnosed with a mental illness.

Suicide and suicide attempts can be seen as indicators of mental health. The suicide rate for the Windsor-Essex and Chatham-Kent community is higher than the provincial average, and more so for males than females, a trend that has steadily increased since 1991. Standardized rates for hospitalization for mental illness are also higher in this area than the provincial rate, for both males and females.

Weight can also be an indicator of health. More residents in Windsor-Essex and Chatham-Kent are overweight than the provincial average, and less have an acceptable weight or are underweight when compared to the provincial average. Anorexia nervosa remains the number one killer of adolescent girls in North America, and obesity is threatening our children under the age of 10. Despite being the first treatment centre location for eating disorders in the province, Windsor-Essex and Chatham-Kent is grossly underfunded for those services in comparison to the rest of the population on a per capita basis. Windsor-Essex and Chatham-Kent residents demand their fair share of the funding regarding services for mental health.

1340

(2) Prohibit two-tier medicine and extra-billing.

Fundamental to the universality of the public health system are the prohibition of two-tier medicine and extra-billing. The threat of two-tier health care has grown significantly with the privatization of the health care system. For-profit health corporations see user fees, service charges and two-tier access as a potential new revenue stream. They are pursuing these in a much more aggressive way than their non-profit and public service counterparts ever contemplated. In addition, the delisting of services has allowed the growth of two-tier access for uninsured services.

Non-profit agencies have suffered increased costs for administering services such as travel, phone, rent, office supplies and communication technology. Without an increase to the agencies providing the programs and services, cuts to these services have been made. One of the more highly publicized issues is in the children's mental health system, where there are up to 1,000 on waiting lists. For adult mental health services, hundreds and hundreds are on waiting lists throughout the entire system.

Although non-profit mental health services and programs do not charge user fees, clients with a mental illness are affected by this practice when other medical facilities such as labs and for-profit care facilities charge

for delivery, notes, forms, scans etc. These costs are prohibitive, especially for those who are debilitated by their illness and unable to sustain gainful employment. Given the current cost and accessibility to publicly funded physiotherapy and rehabilitation services, persons with a mental illness end up going without service. For Windsor-Essex and Chatham-Kent residents, about 19% of the general population indicated an unmet need for medical service, well above the provincial average at 12%. Persons with a mental illness are often residents of long-term-care facilities. The practice of user fees is common among for-profit establishments, causing this population to further miss out on required medical treatments.

(3) Create a health quality council to report on compliance with the principles of the Canada Health Act.

The OASW strongly supports the installation of the democratic process in determining the membership of the council. The council should be representative of the population it serves: the citizens of Ontario. Either by appointment or election, the members of the council should be patients, advocates, experts and workers in the field. We oppose appointments made by the government. No person having a financial interest in for-profit health care corporations should be allowed to sit on the council.

A required role of the council should be to investigate how the health system conforms with the principles of comprehensiveness and universality, as well as accessibility. It should have the power to make recommendations regarding these issues and should be required to conduct its operations in a completely transparent manner.

(4) Prohibit block fees and charges that create a barrier to access.

We oppose block fees, and we believe that Bill 8 should simply ban the practice. They violate the principles of the Canada Health Act and create a barrier to accessibility.

Bill 8 brings the regulation of block fees under the control of the government. We support and applaud the prohibition against physicians and other practitioners opting out of OHIP. Moreover, it allows the bills' regulations, which are unspecified, to determine whether and how block fees can be charged. However, we are concerned that the wording of the bill allows this protection to be reversed in the regulations to the bill, thereby providing less protection than we already have in Ontario law. Government should not allow physicians to extra-bill by regulation.

Physicians across the province are charging patients for uninsured services by use of a block fee in which they set out a specified price to cover all services provided during a year. This is unnecessary, as physicians can charge on an item-by-item basis for those uninsured services. These services might include telephone advice, telephone prescriptions, medical assessments, notes and other professional consultations. Some of these services have been delisted and some were never listed.

To date, the regulation of this practice, such as it is, has been governed by the college of physicians' policies.

However, getting information on what charges are allowed and at what levels and whether a physician can force patients to pay block fees is very difficult. We have been unable to get from the college a list of the services for which physicians can charge. We can get the list from the Ontario Medical Association if we pay a fee of more than \$100.

Technically, the college requires that physicians allow patients to make the decision about whether or not they will pay block fees and cannot refuse a patient who will not pay in this manner. Patients, especially those with a mental illness, are unlikely to make complaints or know how they can make complaints if compelled by their physicians to pay the fees or if they are being charged inappropriately. In the context of a severe shortage of doctors, a system that allows block fees is open to abuse, and patients have few choices to leave a physician, since they cannot find another one.

Further, the preamble of the bill sets out a commitment to primary care. This section of the bill should address the transition to a team-based, salaried, reformed primary care model such as that used in community health centres.

(5) Ensure Public Accountability, Democratic Control and Transparency.

Part III of Bill 8 sets out far-reaching powers of the minister to order individuals and organizations to comply with seemingly unfettered ministerial initiatives. Under these provisions, the minister can direct any health resource provider, person, agency or entity to enter the accountability agreements ordered by the minister to those under his direction.

There is little limitation on who might be required to enter into such an agreement. There is limited guidance in the legislation regarding what might comprise an accountability agreement, and the minister can vary, terminate or issue a new agreement at will.

The bill specifically refers to value-for-money and fiscal responsibility, as well as transparency, quality improvement, and public reporting on the list of matters this section covers. However, it can cover any other matter using personal discretion.

Further, the bill allows the minister to enforce compliance according to consequences that are left to unspecified regulations. The bill provides that ministerial orders can cover reduction or variation in a person's term of employment, including compensation, and where this is contrary to his or her contract, the bill determines that such change will be deemed to have been mutually agreed upon.

This section allows the minister to order fundamental changes in the health system with little, if any, public consultation, procedural safeguards, transparency or other checks and balances.

We believe the health system should be accountable to the people of the province and not to the minister in a top-down fashion. We insist that the minister be accountable for the health system and for democratic control and diverse representation on boards and governing bodies. We insist on mechanisms for public access to financial

information about the health system, whistle-blowing protection for health care workers and public consultation prior to any changes in the health system. The bill must outline in detail the accountability process for providing stable, multi-year funding prior to the end of the fiscal year.

(6) Stop privatization and ensure democratic public/non-profit delivery of services.

The threat to the future of sustainability of medicare posed by private for-profit corporations is critical. P3 hospitals put billions of dollars of public funds into the hands of profit-seeking corporations for whom a veil of commercial secrecy obscures public scrutiny over profit-taking and misuse of public funds. Providing a public service and maximizing profits is a breeding ground for fraud and outrageous salaries, legal fees and higher borrowing costs, which all drive up the cost of health care.

1350

The Canada Health Act calls for the public administration of the health system, recognizing the inherent threat posed by private insurance corporations. Private hospitals, long-term-care facilities, labs and home care corporations are a serious threat to the future of Ontario's health care system. Additionally, it is a common practice of OHIP to send patients needing mental health care to the United States for specialized drug, alcohol and eating disorder treatment. For eating disorders, a three-month stay at a treatment centre in the US for one person represents a cost to Canadian taxpayers of over \$500,000. This could fund an entire year of service for 300 patients in Windsor-Essex county and Chatham-Kent.

Privatization cannot meet the needs of people who are disadvantaged in any way: visible minorities, single-parent families, low-income earners and students. There are over 5,000 visible minorities in Windsor, representing 14% of the youth population. Seventy percent of the female sole-support families use food banks and often go hungry, and 57% had gone hungry within the past 30 days of a recent survey on hunger.

With the fact that the number of immigrants in urban Ontario has increased by an average of 13% since 1997 and the fact that English-as-a-second-language programs have declined by 23% in that same period, a diverse population of linguistically, socio-economically, racially and ethnically disadvantaged students are attending our schools, further limiting their opportunity to understand and afford services available to them.

There are more children living in low-income, single-parent households and a higher number of new immigrants and foreign-born in Windsor to date. This is an increase of 19% since 1996. Among the many factors that put students at risk are aboriginal status, recent immigration status, mobility, physical or mental disability, low family income, low parental education, single-parent status, health issues and inadequate nutrition. Most of Ontario's urban areas have a higher proportion of children who have those risk factors. Privatization excludes our most vulnerable citizens.

The current government ran on a platform of stopping the Americanization of our health care system. The pre-election promise was very clear that they opposed sweeping privatization and were committed to rebuilding medicare. We expect this government to roll back privatization and prohibit future for-profit control of our health care institutions. P3 hospitals must be banned, and services provided through private clinics must be returned to hospitals and non-profit agencies.

The Chair: Thank you very much. The time is 1:55 and you started at about 1:35, so you've used about 20 minutes. Why don't we each take four minutes, starting with the official opposition.

Mr Klees: Thank you for your presentation. I'd like to get your thoughts with regard to the composition of this health quality council. You make the point that you oppose appointments made by government and that there should be a democratic process in determining the membership of the council. Could you share with us how you envision that, how that process would work at a practical level?

Ms Lucier: I think there could be a call for nominations. There could be a nominating committee that would call for nominations, and people would submit their applications.

Mr Klees: So this would be a public call for nominations, open to anyone; anyone could nominate a specific person. Would the Ministry of Health have administrative responsibility for receiving these nominations, or do you see an independent body doing that? Do you trust the Ministry of Health to do this?

Ms Lucier: I think it could be done within the Ministry of Health, and there could be criteria about the nominations. Nominations should be accepted based on the interest of the person: for example, as I said, consumers of the health care system and workers in the field, experts, citizens of the community. But I do believe that piece of it could be managed within the ministry.

Mr Klees: Do you have in mind any specific group that would be excluded from being nominated to participate in this group?

Ms Lucier: As I said in the report, anyone who was on a board or working for a for-profit health organization.

Mr Klees: What about someone who is on a board of, say, a hospital? These are typically volunteers who have many years of experience in the health care field and often have been on the front line of recognizing what is wrong with the system. Do you think they should be excluded as well?

Ms Lucier: No. I think they do have valuable experience to bring to the council.

Mr Klees: OK. With regard specifically to the block fees that you refer to—you oppose block fees. There are obviously two sides to this issue. We've had representations from physicians who put forward their side, saying, "Look, OHIP only covers a certain number of charges, yet we are also subjected to a number of other requirements from our patients," whether that be answer-

ing phone inquiries, doing medicals for employment purposes—a range of things that physicians are asked to do. As busy as they are, their point is, "We can't afford not to charge for these things, or we simply have to say we can't do them." Your response to that would be what?

The Chair: A really brief response.

Mr Klees: Are you suggesting perhaps that all those services provided by a physician, should be covered under the OHIP fee schedule?

Ms Lucier: We were also recommending that a health care community practice be adopted, as opposed to the individual physician, so there could be a cut in the costs that way also—shared expenses.

Mr Klees: So you envision, then, that in these group practices, all services a physician offers would be covered off by whatever they're being paid under that arrangement.

The Chair: Ms Martel.

Ms Martel: Thank you for being here today. We've heard from three social workers now in three different communities, but each one has brought some of the local concerns forward, which has been most useful in this case, because it does involve mental health.

You've also brought forward some general concerns, and may I just say that I appreciate that you continue to talk about why we need to get away from two-tier private health care because, as far as I'm concerned, that's money that should be going into patient care, and money that ends up in somebody's pocket in terms of a profit. So we really do need to get away from the P3 hospitals and from private MRIs and CAT scans. Frankly, we should also be ending the competitive bidding in home care, which does the same thing and diverts money away from home care patients.

I want to just ask some general questions in terms of the information you provided. On the back, you talked about the common practice of OHIP to send patients needing mental health help to the United States. Because you have such a serious problem in Windsor, do you have some information locally about how many people might actually be accessing acute—I'm assuming that's what it is—mental health care services across the border somewhere else?

Ms Lucier: I can only speak from the eating disorder perspective, because my employment is with a bulimia-anorexia nervosa association. We have a treatment centre here in Windsor. At one time before we had our funding, there was a significant number going over to the United States, but because we exist here, that's been curbed in Windsor-Essex. The figure I gave you came from the Soo, which is a northern community. I understand that in the other underserved areas there are a number, but I don't have a number.

1400

Ms Martel: Does your eating disorders clinic serve adults or children?

Ms Lucier: Both.

Ms Martel: Both. You're lucky in that regard. At home we've been desperately trying to get a children's

service for a long time, to no avail, unfortunately. How many patients do you—

Ms Lucier: We see about 300 a year.

Ms Martel: What's the breakdown between adults and children? Do you know that?

Ms Lucier: There are about 95 adolescents and the rest adults. Adolescents would be 12 to 15.

Ms Martel: You were talking about delisting of services and said that “clients with a mental illness are affected by this practice” of charging user fees “when other medical facilities such as labs and for-profit facilities charge for delivery notes, forms, scans etc.” Can you give the committee some example of what's happening? Are you talking about your own clients? You talked about mental illness, so you might be splitting that.

Ms Lucier: Well, our clients are struggling with the mental illness of eating disorders. In our centre, it's very common that they would turn toward us because they view us as their lifeline of support for them, and they cannot afford travel back and forth to the medical facility to get any of the blood work they need done. If we require corresponding blood work as it relates to starvation or other medical tests, doctors are routinely charging to read our referral form and routinely charging to provide any written feedback on how the patient is doing, which is crucial to our treatment planning. So they're looking to us to fund them, because many of them are unemployed because of their illness and they can't afford it. We haven't had an increase to service in a number of years, so we're looking to other fundraising sources and scrambling, which takes time and effort away from patient care.

Ms Martel: Let me just be clear: Your agency does not have family doctors per se; you have a number of clinicians who work—

Ms Lucier: We have a family physician who is a consultant and gives us two hours a week to look at our clinical diagnoses and recommend medical treatment based on what we present.

Ms Martel: So for anything over and above that, patients have to go back to their own family doctors, and it's at that point where charges may or may not be applied to get that work done?

Ms Lucier: Exactly.

Ms Martel: I'm going to assume that most of your clients, your adult population, would be on a fixed income.

Ms Lucier: Yes. But some of the teenagers, 16 to 19, don't want their family members to know, and they're not working at all, so they can't afford to pay for it.

The Chair: Ms Di Cocco, then Ms Smith.

Ms Di Cocco: Thank you, Ms Lucier. You make a compelling presentation in regard to not only your profession but also about some of the needs that are there. It's important for me to reiterate this process we're applying. As you know, this proposed legislation is here after first reading, which doesn't happen too often, meaning that we're shaping it, in many respects, through input such as what you've provided. We feel it's a better

approach in ending up with a final product. So the suggestions you've provided with regard to consultation and/or makeup of the health council are valid. I guess what I want to say is how important it is, in this process of getting to a final product of legislation, that we incorporate the suggestions, that it isn't a fait accompli. I want to assure you of that, because otherwise we would be here after second reading. The modus operandi of the past has been that it was a fait accompli and therefore there were just the semantics of being in front of a committee. Thank you very much for your compelling discussion.

Ms Smith: I too want to thank you for coming and for preparing this brief for us and bringing to light a few things, some of which we've heard from your co-workers, the social workers, but it's nice to hear the specifics from your area. I was happy to hear your discussion with Mr Klees about your suggestions for the makeup of the council. That was one of the questions I was going to raise.

I just wanted to quell some of your fears on the accountability and democratic control portion of your presentation, where you raised some concerns about the legislation, as it's now drafted, with respect to unfettered ministerial initiatives and whom the accountability agreements will apply to.

The minister made a statement on Monday wherein he set out some of the amendments to this legislation that he sees coming forth in clause-by-clause, one of which would be to specify that the accountability agreements will apply to hospitals, CCACs, LTCs and independent health facilities. That narrows it, so I hope your concerns are somewhat lessened. As well, we will be setting out in the amendments, procedures for how these agreements will be entered into as well as procedures around the issuance of compliance orders and compliance directives, which I think will go a long way to calm your fears on that particular as well.

You talked about also wanting to see “public access to financial information about the health system, whistleblowing protection for health care workers and for public consultation.” In fact, this hearing, as Ms Di Cocco pointed out, is a good example of a first step in public consultations on changes to health care. Certainly our government is committed to that.

Also, public access to financial information: One of the functions of the council will be to provide information back to the public on how our health system is faring and what we're doing, and that's really one of the major focuses for the council. That will be a big, positive increase in information for the public.

Whistle-blowing protection: There is some in this legislation, and we intend to toughen that up a little bit in the amendments to make sure that people feel comfortable coming forward and reporting misuses of our health dollars.

I just want to thank you again for coming. I'll give you a copy of the minister's statement as well.

The Chair: Ms Lucier, your time is up. Thank you very much for coming today.

HÔTEL-DIEU GRACE HOSPITAL

The Chair: I call forward the representatives from Hôtel-Dieu Grace Hospital at this time. As I understand it, this afternoon we have with us Ken Deane, the president and CEO; Gerry Trottier, former chair; and Mary Fox, the vice-chair. Come forward and make yourselves comfortable. There's some water over there, if you'd like some. There will be the same rules as everybody else. You get 30 minutes. You can use that any way you choose. If at the end of your presentation there is time remaining, it will be split among the three parties in the order of the third party, the NDP, first, then the government side and the official opposition.

Ms Mary Fox: Perhaps I will start. As you can probably gather, being the only female here, I'm Mary Fox. To my immediate right is the president and our chief executive officer of Hôtel-Dieu Grace Hospital, Ken Deane, and immediately to his right is our past chair, Mr Gerry Trottier.

Firstly, let me thank you for the opportunity of letting Hôtel-Dieu Grace be here today to present some brief comments and recommendations regarding Bill 8.

At the outset, I want to say that Hôtel-Dieu Grace Hospital supports the need to have greater accountability in the system and, secondly, that we welcome greater clarity regarding the relationship between government as the funder and the hospital as the provider.

We do have some concerns regarding Bill 8, and I want to identify and highlight four general concerns and will be more specific in our presentation.

Firstly, we're not convinced that the case has been made out for this bill in its current form.

Secondly, we do not believe that the bill will yield the anticipated changes. In effect, it could have unintended negative consequences.

Thirdly, the bill potentially erodes local voluntary governance.

Lastly, the bill does not adequately recognize the circumstances that affect financial performance of hospitals.

I'll make seven points with respect to the view on Bill 8 from the board perspective. A pillar of our hospital system in Ontario is community involvement through voluntary local governance. The effect of Bill 8 is to decrease accountability to local communities by fundamentally undermining the role of voluntary local governance of public hospitals in communities across this province. This, in our respectful view, will irrevocably alter the relationship of hospitals to their communities.

1410

Our second point is that the accountability provisions of Bill 8 do not sufficiently recognize the interdependent nature of the relationship between health care providers and government, one that historically has been characterized by trust, mutual respect and collaboration and that should continue to be so characterized.

Thirdly, directing hospitals to sign agreements undermines the collaborative approach adopted by both government and hospitals to develop a multi-year funding

framework and performance agreements for hospitals. Imposing agreements on a hospital undermines the role of the board in ensuring that the necessary health care services are provided to the community.

Fourthly, the compliance directives in Bill 8 are inappropriate in the context of a negotiated agreement. This appears to be an intrusion upon the role of the community and the hospital board and has the very real potential for undermining voluntary governance in local communities.

Fifthly, the provisions that allow the minister to make an order that may result in a material change in a person's employment, such as the one who is sitting immediately to the right of me, including a reduction in pay or change in benefits, are inconsistent with common law. Under the Public Hospitals Act, the terms of employment of the chief executive officer are for the board to determine and modify as the board deems appropriate.

Hôtel-Dieu Grace Hospital is a denominational hospital. Catholic health services strive to provide the highest quality care with respect and compassion to all in need, regardless of religion, socio-economic status or culture. We collaborate in open partnerships with other members of Ontario's health care system, and we are dedicated to voluntary community governance to ensure accountability to the government and to those we serve in the community. Catholic facilities reflect a proven, community-based, voluntary approach to governance.

My last point is this: In Windsor, Hôtel-Dieu Grace Hospital and Windsor Regional Hospital are committed to integration, and we have instituted a number of changes aimed at strengthening the level of that interdependence and interconnectedness. As an example, integration has been advanced by establishing shared vice-president positions between the two organizations and, additionally, there has been pursuit in the integration of medical staff. In fact, the Minister of Health, the Honourable George Smitherman, stated in his address to the 2003 Ontario Hospital Association convention, "In Windsor we are seeing an inspiring example of two hospitals putting their competitive past behind them and working together to enhance the delivery of care and to bring their deficits under control. And the big winners are, of course, the people of Windsor."

From the board's perspective, we see Bill 8 as undermining some of these initiatives.

Putting forward the view from administration will be Mr Ken Deane.

Mr Ken Deane: Thank you. I'm pleased to be here as well to present on Bill 8.

Many hospitals incur operating deficits due to patient demand or because the funding announcement was too late to achieve the necessary savings in the fiscal year or costs exceeded funding and the ministry precluded service reductions that would allow hospitals to balance budgets. In fact, some of the most efficient hospitals in Ontario are running deficits.

To put that in context, it is now February 19, and the new fiscal year commences in about six weeks. At this

point, the hospital sector does not know its funding increase for fiscal 2005 or the salary increases that will be negotiated. However, given the arbitration award for OPSEU, we're anticipating salary increases of about 3.5% to 5%. The directive from the ministry each year is to achieve a balanced budget, and we certainly emphasize that within our organizations and support the need for fiscal stewardship. However, service reductions have not been allowed as a means to balance budgets. The expectation is that hospitals can achieve efficiency improvements to make up the gap between funding and expenses.

Over the past 12 months, as part of an organizational turnaround at Hôtel-Dieu Grace Hospital, we've moved aggressively to improve operational and clinical efficiencies as part of an organizational turnaround, with the result that, first, we are operating with 100 less full-time-equivalent staff this year than last, and 70% of our cost centres are operating in the top quartile; the remaining 30% that aren't are not because of safety or patient-risk-related reasons, and we're quite comfortable with their level of efficiency. Our focus is on the continuous operational improvement of our organization. However, hospitals can reach the point of diminishing returns and can increase risk by increasingly pushing the efficiency part.

This year, for example, we are expecting to break even, excluding one-time restructuring costs. This compares to operating losses of \$4.6 million in 2003 and \$15 million in 2002. Notwithstanding this change in performance, our fiscal 2005 forecast is an operating loss of \$7.7 million based on assumed increases due to negotiated settlements, benefit cost increases, utilities and drug cost increases. The significant cost of drugs is reflective of the significant role that drug therapy plays in hospitals and the increasing costs related to new technology within pharmaceuticals. The forecast shortfall of \$7.7 million translates into an operating funding requirement of 6.4%. Given that the new fiscal year starts in six weeks, if funding does not cover the expected cost increases, we would be unable to achieve a balanced budget in this year because of notice periods that require up to six months. So we could not achieve a balanced, break-even position this year if funding doesn't match expense increases.

End-of-year deficit funding has been identified as a major problem within the health sector. The stated policy has been that hospital budgets are fixed, but in practice hospitals are told not to cut services in order to break even. Deficit funding invariably followed as a year-end adjustment, recognizing the patient demand in communities.

There is an inherent conflict due to the fact that hospitals are funded on a fixed or global basis and physicians are funded on a volume basis through fee for service. That creates an inherent conflict in hospital operations.

Our area is considered by the Ministry of Health as an underserviced area for family physicians and specialists. Consequently, we spend approximately \$1 million per year for hospitalists to provide care to unattached patients and for internal medicine specialists to provide on-call

coverage in our hospital. Under Bill 8, this would not be allowed, resulting in major problems in the provision of medical care, such as delays in tests and treatment, increasing lengths of stay, increasing waits in emergency departments and physician and staff burnout.

In addition to the integration that has occurred within the city of Windsor, it's important to acknowledge what's going on in our geographic area. There are three hospitals in Essex county: the Leamington hospital and the two Windsor hospitals. The three hospitals are working together to take an overall approach within our geographic area. For example, we're recruiting a regional chief information officer to facilitate the development of a region-wide information systems plan. So we are very supportive of integration and are moving in that direction.

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Mr Gerry Trottier: The Hôtel-Dieu Grace Hospital board and administration have a set of seven recommendations for the committee's consideration.

The first recommendation is that Bill 8 be considered to be amended in the following ways:

- to enhance the accountability of providers and government to the citizens of Ontario in a manner that is consistent with the collaborative nature of health care, as Ms Fox just mentioned;

- to provide for the negotiation of accountability agreements rather than the direction that such a paper be signed; in fact, a directive to sign a piece of paper is antithetical to it being an agreement. It must be by consensus.

- to delete the requirement for compliance directives, which fundamentally alters the nature of governance of public hospitals in Ontario as it is today;

- to provide for multi-year agreements so that financial planning and the achievement of clear objectives is known and can be assessed over a period of more than one fiscal year; and finally

- to amend Bill 8 by deleting the provision that would allow the minister to make an order resulting in a material change in a person's employment, which also removes any opportunity for the individual or an institution to have recourse to any remedy at law that it might otherwise have.

Our second recommendation is that the ministry update the Public Hospitals Act. If significant changes to governance of hospitals in Ontario is to be undertaken, it should be looked at in a global way.

Our third recommendation is that the ministry and the Ontario Hospital Association work together to promote and facilitate standardization across the hospital sector, including standards for information systems, data quality, safety, the provincial drug formulary and non-core services. This standardization will permit a greater ability to assess performance, which is an inherent component of accountability.

Fourth, we recommend that the government establish arbitration guidelines for collective agreements and/or establish the principle that arbitration awards or negotiated settlements will be funded. As Mr Deane pointed

out, it is very difficult for hospitals to adjust in a period of six weeks in order to be able to assume and deal with external expense factors beyond our control.

Our fifth recommendation is that the ministry advance performance agreements that also incorporate the responsibilities and deliverables of government and recognize the uncontrollable factors that influence hospital operations, including decisions of other ministries. Members of the committee can well imagine the effect on hospitals of the deregulation of utility rates, a very significant element of our expenses on an annual basis.

Our sixth recommendation is that the ministry implement service-based funding and provide a transition process for hospitals. In this way, communities will know what the anticipated level of service is.

Our seventh recommendation is that the ministry establish an arm's-length commission to establish the price per unit of service and review requests for deficit funding. In that way, public hospitals and boards may know what the expected cost is of delivery of a known volume of service which is approved for a geographic area.

We thank you for this opportunity to speak with you today, and we'd be delighted to answer your questions.

The Chair: Thank you. You've used up about 18 minutes of your time, which leaves you with 12 minutes for questions. We'll start with Ms Martel.

Ms Martel: Thank you for being here today. We appreciate your participation.

I'm going to go to the section "View from the Board," because there are a number of concerns outlined in there, concerns we've heard before. They were concerns I had hoped would be addressed by the minister in terms of amendments which were going to come forward.

We received earlier today, and you wouldn't have known this because we just got this, an indication from him of where some changes would be made. I'm looking at the sections around the accountability agreements and note that in the changes that came to us I would have hoped that somewhere it would have said that these were going to be negotiated. I don't see the word "negotiated" anywhere yet in the changes that are before me.

I see some other things that continue to concern me. Let me deal with section 22. You've said that the compliance directives in the bill are inappropriate in the context of a negotiated agreement, and I agree with that. The proposal doesn't seem to make much change in this regard. We don't have the exact language, but the proposed thoughts leading to the language say the following: "Include notice and other due process provisions, including time frames for notice, to address development of accountability agreements, issuance of compliance directives and orders (eg, discussion process, meetings, exchange of documents/information, representations that the minister has to consider before issuing a compliance directive or an order.)"

So I don't hear much in the way of negotiation there. I hear the minister having to review some information and have a timetable before he goes and does what perhaps

he wanted to in the first place. I want to know if you think that is going to address your concerns.

Ms Fox: I can answer that, and I can say definitely no. I would view those submissions as simply nothing more than perfunctory. The word "directive" or the word "order" is mandatory. To put some salutary language into it that suggests there would be some ability to put forward resistance statements, co-operative efforts into reaching a collaborative agreement, frankly does not seem to be the effect of the intended amendment. I would underscore it as simply being nothing more than a perfunctory attempt at it.

Ms Martel: OK. Let me give you the next one, because you talked about common law with respect to allowing a minister to make an order that might result in a material change in a person's employment, that that would be inconsistent with the common law because this is the role of the board in relation to the CEO. The language that we have been given says in that section, "Include range of remedies directly in legislation that could be issued in a compliance directive or an order to address non-compliance (eg, audit, budget review etc). CEO compensation clawback or any other financial remedies to be applied to a CEO as a last resort only after all due process has been exhausted and in exceptional circumstances." My read is that there is still an opportunity for the minister to do the CEO clawback. It says, "exceptional circumstances." I don't know what that'll end up being, but it still sounds to me that that would be contrary to common law, because you are the employer, not the minister.

Ms Fox: There is no question about it. The CEO is employed on a contractual basis by the board. He serves at the will of the board, if you will, and to the extent that his services are not as directed by the board or satisfactory to the board, it is the board, on behalf of the community, that makes a determination as to what transpires. The minister's comments cause me concern and, I hasten to add, will cause our board significant concern, because although there is some suggestion at some more modest language, ultimately words such as "directive," "order" and "clawback," albeit under exceptional circumstances, provide the ability for the minister to in essence step into the shoes of the board, to assume the role of the board for governance. In effect, what it really does is do away with the need for boards to do their job.

The Chair: We go on to the government side.

Ms Smith: Thank you for coming today to present us with your views on this bill. As you know, we are coming to you after first reading of this bill, which is unusually early in the process, and we are looking for feedback and input. We appreciate your coming today to do this. As well, as I'm sure you're aware, there have been discussions ongoing with the OHA and other stakeholder groups leading up to these hearings.

The minister, in his statement on Monday, did make a number of statements regarding some of your concerns. I'm not sure if you've seen his address, but I would like to bring a couple of those comments to your attention.

First, of course, he did state that the accountability agreements, as I'm sure you're aware, are expected to be between the boards of the hospitals and the ministry, and not between the CEO and the ministry. Is that your understanding through your discussions with the OHA?

Mr Deane: Yes.

Ms Smith: I understand further that that would not affect governance per se, so when you speak about the Catholic health services that you strive to provide in your community, I don't think those will be affected in any way by the implementation of accountability agreements. Is that your understanding?

Mr Trottier: If the accountability agreement is negotiated in the true sense, then that will go a long way toward addressing our concern, but if we are directed to sign a piece of paper, that is no agreement.

Ms Smith: Right. The minister in his statement on Monday said, "Bill 8 is a big step toward greater accountability in the system. It creates a framework that allows the minister to establish negotiated accountability agreements with publicly funded health resource providers. The health care providers we intend to designate in the bill are hospitals, community care access centres, long-term-care facilities and independent health facilities." So I think he has indicated in effect that these will be negotiated.

I'm just a little curious about the tone of your presentation. Are you against accountability agreements?

Mr Trottier: As they're described in this current bill, yes.

Ms Smith: Are you against any accountability agreements?

Mr Trottier: Oh, no, not at all. In fact, we welcome them, because then it will clearly define the parameters of the relationship between the hospital as the provider and the ministry as the funder, and it will clearly define for the public in a transparent way how both of us are accountable.

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Ms Smith: I think that's the intention of this act, to implement these types of agreements so there is transparency and the public is aware of where their funds are being spent in health care.

Mr Trottier: Then what I would recommend to the committee is to seriously consider amendments, first of all, to section 21, which states, "A health resource provider, and any other prescribed person," which can include a CEO, "... shall, when directed by the minister ... enter into an accountability agreement," which does not describe a negotiation process.

Ms Smith: If I could just comment on that, I think the minister did address the tone of the legislation in his opening remarks on Monday as well. I think he did say that there will be changes to that as well.

Mr Trottier: And we look forward to seeing the language that implements that. I would also point out section 24, which states, "The minister may at any time terminate an accountability agreement or a compliance directive, and may at any time vary a compliance directive or issue a new compliance directive." That has

the effect of overriding an accountability agreement, in my view.

The Chair: Mr Klees.

Mr Klees: Thank you very much for your presentation. I'm wondering, based on the exercise we've engaged in with stakeholders from across the province over the last four days, what you folks have done to deserve this bill. On the one hand, you quoted the minister complimenting you on the good work that you've done. By the way, hospitals right across this province have worked very co-operatively under some pretty strict obligations as well, under other acts in this province, to become efficient and to do the right thing.

The minister admitted on Monday that this bill is seriously flawed. However, surely the minister read this bill before it was introduced, and surely the minister, who is fairly intelligent, would have drawn the same conclusions that you did about the punitive actions, the draconian measures, the undermining that it does of a volunteer board, the encroachment, the reaching into agreements of all types, whether that be a CEO's employment contract or other contracts. Why, in your opinion, did the minister feel it important enough to bring a bill like this forward? What has this sector done to deserve this?

Mr Trottier: I can't answer that question. However, I do share your concern that the way the bill is currently worded, including certain punitive measures, will act as a disincentive for persons of good faith and talented people in the community to first of all be voluntary board members, with fines of up to \$50,000 in the event that you inadvertently have an assigned billing for otherwise insured services. That's a very serious concern for me as a board member, to be subject to that kind of potential punitive provision. But more important, I think it acts as a significant suppressive factor in excellent people, such as Mr Kenneth Deane, sitting next to me, wanting to be hospital CEOs, particularly with respect to sections 27 and 28, which are—I would share, in those particular elements, your view that they are draconian, that a CEO's salary be clawed back in situations where the CEO may not have responsibility.

Mr Klees: By the way, with regard to that, when it was pointed out in these committee hearings that section 27 is in fact draconian, has serious repercussions to the sector, the minister undertook to provide clarification. Here is what his clarification is relative to section 27: This "would only apply to CEOs (not trade unions or other employees)." So once again I say, Mr Deane, you're not at all comforted by this clarification, are you? I would certainly have questions, if I were you, notwithstanding the fact that not only does the minister reserve the right to get into your contract, but he also is saying that when he does, you will be deemed to have agreed to that, and you have no recourse. How does it feel to be such a special class of person in the province of Ontario?

Mr Deane: I've always considered my position to be special.

Mr Klees: Not many people will want to join you after this.

The Chair: On that note—

Mr Deane: We're done?

The Chair: We are done. Do you have something to say very briefly?

Mr Deane: I just wanted to make a brief comment. When the question was asked about whether we support accountability agreements—we do. In fact, our board has supported my involvement in the joint policy and planning committee, where I serve on the operations steering committee, the multi-year funding executive committee, and I chair the hospital funding formula committee. So we are, as an organization, committed to accountability and want to advance accountability relationships within Ontario.

The Chair: Point well made and taken. Thank you for coming today.

WINDSOR AND AREA HEALTH COALITION

The Chair: If I can now call forward the representatives from the Windsor and Area Health Coalition. I understand that we have Mike Longmoore, who is the chair; Rob McGuffin; and Darlene Prouse, who is the vice president of the Canadian Auto Workers local 2458. Be seated. There's some fresh water there if you need some. You have 30 minutes, like all the other delegations, to use as you wish. Should you have any time left over during that period, we'll use that time up with questions from the three parties, starting this time around with the government party, the Liberals. The floor is yours.

Mr Rob McGuffin: Good afternoon. On behalf of the Windsor health coalition, I'd like to welcome the committee to Windsor, and I'd like to thank you all for this opportunity to speak to you.

Bill 8, the Commitment to the Future of Medicare Act, was introduced as a fulfillment of the Liberal Party's promise to enshrine the Canada Health Act in Ontario law, create a health quality council to monitor and provide accountability, and prohibit two-tier health care. As it stands, the bill does not further the implementation of the principles of the CHA; does not provide improved democracy, transparency and accountability; and does not prohibit the further erosion of the scope of medicare and the increasing problems of privatization and profit-taking of the two-tiering for those services that have been delisted. We must rebuild a commitment to universality, comprehensiveness and accessibility of medicare.

Over the last decade, \$100 million in OHIP services have been delisted. Homemaking and home support services have been virtually eliminated across the province, lowering caseloads from 2002 to 2003 by approximately by 115,000 people, often the frail and elderly. Drug costs are prohibitively high and inaccessible for a growing number of Ontarians. Bill 8 incorporates the principles of the Canada Health Act in its preamble, but provides no concrete initiatives, either to ensure access to these services that have been cut or to implement the sentiments outlined in the CHA.

As noted in the preamble to the bill, home care and pharmacare are key components of rebuilding an accessible, comprehensive, universal public health care system. So too are homemaking and support services, access to primary care, access to drugs and assistive devices, and comprehensive OHIP lists covering these services that people need. The intent of the Canada Health Act was to ensure that Canadians have access to a comprehensive range of medically necessary health services. Real, concrete steps are needed to fulfill this vision.

We must prohibit two-tier medicine and extra-billing. Fundamental to the universality of the public health system are the prohibition of two-tier medicine and extra-billing. The threat of two-tier health care has grown significantly with the privatization of the health system. For-profit health corporations see user fees, service charges and two-tier access as potential new revenue streams and are pursuing these in a much more aggressive way than their non-profit and public counterparts ever contemplated.

Private MRI/CT clinics are allowed to provide scans to those who pay out of pocket for so-called medically unnecessary scans. Therefore, those with the least medical need can jump the queue. In addition, the opening of private MRI/CT clinics has resulted in technicians leaving publicly funded hospitals to reap bonuses offered by the private clinics, putting even more strain on the overburdened public system. This was the case in Windsor this past summer, as a technician left a local hospital to go to a private MRI clinic, lured by a \$10,000 signing bonus.

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Bill 8 must be changed to stop the two-tiering for so-called medically unnecessary scans that is allowed in the private MRI clinics. There is no public interest justification, either in providing scans to people who don't need them, and incidentally exposing them to radiation in the process, or in shuffling the queue to allow those with no medical need to get service before those with medical need.

Bill 8 must also anticipate and prohibit increases in fees and charges levied by the for-profit corporations in search of a new revenue stream as they take over more health facilities. The government campaigned against P3 hospitals and private clinics. They should fulfill their campaign promises and stop and reverse these privatizations. In addition, as the scope of medicare has been reduced due to delisting and underfunding, the bill should protect against two-tiering for all the services that have been delisted and any further erosions of this sort.

We must create a health quality council to report on compliance with the principles of the CHA. Given the CHA principles enshrined in the preamble to this bill, it is surprising that the health quality council outlined in part I does not ensure reporting on the extent to which the health system conforms with those principles. Further, it is not required to report on issues relating to two-tier medicine, extra-billing and user fees.

No person who has a financial interest in for-profit health care corporations should be allowed to sit on the council. Rather than an appointed body, this council should be composed of a democratically selected group appointed by all parties that represent patients, advocates and workers, as well as the so-called experts. The council should include representatives from diverse groups as well as from geographically remote areas and equality-seeking groups.

The council should be required to investigate how the health system conforms with the principles of comprehensiveness and universality, as well as accessibility. It should be required to report on two-tier access, user fees, service charges and extra-billing. Further, this democratically represented council should have the power to make recommendations regarding these issues and should be required to conduct its operations in a completely transparent manner. We must stop privatization and ensure democratic, public, non-profit delivery of service.

The threat to the future sustainability of medicare posed by private, for-profit corporations is critical. P3 hospitals put billions of dollars of public funds into the hands of profit-seeking corporations for which the veil of commercial secrecy obscures public scrutiny over profit-taking and misuse of public funds.

In their endless search for profits, corporations seek new sources of revenue, imposing fees and service charges whenever they can, and motivations and means for increasing two-tier health care are increased. The result is that the scope of services offered under the public system are reduced. Beds and staff are cut; patients face a barrage of new fees; two-tiering increases; public accountability and access to information are reduced; democratic control is reduced; advertising, consulting and legal costs go up; fraud goes up; and executive remuneration goes up. More and more of the health system is governed by a bottom line of profit margin and rates of return for investors.

The Canada Health Act calls for public administration of the health system, recognizing the inherent threat posed by private insurance corporations. Similarly, private hospital corporations, private long-term-care corporations, private labs and private home care corporations are a serious threat to the future sustainability of Ontario's health system.

The current government ran on a platform of stopping the Americanization of our health system. The pre-election promise was very clear: They opposed creeping privatization and committed to rebuilding medicare. Any legislation purporting to show this government's commitment to the future of medicare must include concrete initiatives to roll back privatization and prohibit future for-profit control of our health care institutions. P3 hospitals must be banned. The private diagnostic clinics must be returned to non-profit hospitals. The tide of privatization sweeping across our health system must be stemmed. The future sustainability of medicare and the application of the principles of the Canada Health Act depend on it.

Ms Darlene Prouse: I'm Darlene Prouse, vice-president of the CAW, local 2458. I thank you for allowing me to speak. First of all, I would like to acknowledge the commitment from Health Minister George Smitherman to correct Bill 8's flaws. His statement that the bill does not affect the current collective agreement offers little relief to health care workers, as many agreements expire this year. The provincial Liberals' response to the Romanow report, in the first draft, requires tightening of the language and further clarification of the intent of the language.

The assurance that the bill, in its original content, has been misinterpreted by the public and not intended as such is reassuring as we await the amendments. As representative for one of the unions representing many of the health care facilities in Windsor and area, I feel I must voice my concerns regarding the accountability portion of this document. Of concern, of course, is the protection of current and future collective agreements. Any suggestion of opening these agreements with the intent of reducing compensation or benefits is not an appropriate solution to the financial recovery of our health care system. This bill should not be a deterrent to the current and future collective bargaining processes. If the intent is not to interfere in these processes, the wording needs to be clarified within the amendments. This issue is also problematic if the intent of opening the collective agreements is cost-saving for health care and opens the doors for contracting out of services, P3s and privatizing.

There also is no restriction on the scope of compliance directions and accountability agreements. Of concern as well is social accountability, or accountability to the public. This will not be assured with the current bill, as accountability falls under the CEOs and hospital boards, reporting their accountability to the Minister of Health only. This needs to be adjusted further for the public's ability to be informed as a whole. Any fundamental changes in the health system without public consultation could prove to be detrimental and not as productive as the intent was meant to be.

Absent from this bill is whistle-blower protection. I would suggest at this that time this language would be welcomed as the federal government is entering into similar protections for public servants. A health care worker who cannot complain or report employers against wrongdoings is denying public consultation and the right to speak out. Whistle-blower protection would also ensure accountability from the bottom up.

I eagerly anticipate reviewing the planned amendments to Bill 8 and sincerely hope that the wording and intent become clear and reach approval from all. Bill 8 should provide the public with advancement to the Romanow recommendations, and the health quality council should become the public guardian that Romanow expected the national health council to become.

Mr Mike Longmoore: I guess we're done.

The Chair: Very good. That took you just 10 minutes, and leaves us with about 21 minutes. That's seven minutes per party. We'll start with the government side.

Ms Smith: I thank the three of you for coming today and presenting to us. As you probably heard in the previous presentation, we are very happy to be bringing this bill forward after first reading, which is unusual, looking for public input into the amendments that we hope to make. As you know, I'm sure, the minister made a statement on Monday in which he highlighted some of the proposed amendment areas that we are looking at. Certainly there are a number of things that we will be tightening up and changing, going forward. We appreciate your input into that.

Let me just quickly address your concern about P3 hospitals; you raised a concern about the two hospitals that are referred to as P3 hospitals. I just want to quote from a statement the minister made in the Legislature on November 27, that our new government has acted quickly to ensure that new hospitals in Brampton and Ottawa are "publicly owned, publicly controlled and publicly accountable."

There has been some talk as well that another six or seven hospitals are being looked at for similar financing. I just wanted to assure you that no decisions have been made with respect to those facilities. Certainly, we're working with the infrastructure ministry to find financing arrangements that will continue to ensure that all of our hospitals in Ontario are publicly controlled, publicly owned and publicly governed and accountable.

I then want to go on to address a couple of your concerns with respect to this bill. You made a suggestion at one point that collective agreements could be opened by this legislation and that there could be an intent to interfere with collective agreements. The minister has made it perfectly clear, and we have made it perfectly clear at least 15 times in the last three days and will continue to do so, that this legislation does not apply to collective agreements and will not affect collective agreements. It does not apply to unions. You have the minister's assurance and you have this committee's assurance that we will be bringing forward specific amendments to the legislation on that point.

1450

You spoke about accountability and the need to make it public. There is a provision in the legislation to allow for the posting of accountability agreements between hospital boards and the ministry, so those agreements could be made public and will be made public. I believe it's the intention that they will be made public, so that those members of the community will know what accountability agreement has been signed between their hospital and the ministry.

I think you're aware, but I'll just repeat it for the sake of repeating myself yet again, that the intention is that the legislation will be amended to provide for accountability agreements between boards and the ministry. Then the boards would enter into performance agreements with their CEOs. There was some concern that the ministry was usurping the authority of boards, but that is in no way the case. The boards will continue to be boards specific to those institutions. We're not in any way trying to affect the governance of those institutions.

You did raise a concern as well about whistle-blower protection. I just wanted to note that in subsection 14(7) there is whistle-blower protection, in the second part of this legislation, to enable health care workers to ensure that health service accessibility is provided. We will be expanding that to explicitly prohibit disciplining or penalizing whistle-blowers. So that assurance is there as well.

I was interested in discussing with you a little bit and asking you a question, if I still have time. I know I'm steamrolling through. Am I OK, Chair?

The Chair: I think you still have about two minutes.

Ms Smith: OK. I'm getting down to a very quick pace these days.

You spoke a bit about your concerns about the health quality council and the membership on that council. You talked a bit about the reporting function, but you also talked about the membership, and you thought it should be democratically selected and appointed by all parties. I wonder if you could expand on that for me a bit, about basically what you mean by "democratically selected and appointed by all parties." What parties would you be referring to?

Mr McGuffin: The parties in government.

Ms Smith: OK. One of the things that we foresee including in the amendments is precluding stakeholder groups from having a seat at the table. So for the large stakeholder groups that exist to represent certain interests in health care, we were looking at precluding their executive from holding a position, but that wouldn't preclude a member like a doctor, as opposed to the head of the OMA. A doctor would still have a role, or a health care provider of any kind, as well as consumers. I think we also want to see regional representation. Are there any other specifics you would like to see included on that council?

Mr McGuffin: Basically what I stated.

Ms Smith: That's kind of what you were looking at?

Mr McGuffin: Yes.

Mr Longmoore: Could I respond on the P3 hospitals?

What we understand is that the main difference between the P3 hospitals of Harris and the public hospitals of Mr McGuinty is that one is a leaseback and the McGuinty proposal is a mortgage. Many of the elements of the P3 hospitals are in place: the operating budgets, privatization of finance, of services, of the land deals. I just wanted to quote John Baird, who is a former cabinet minister in the Conservative government:

"Dalton's tie might be red, but his whole suit is blue. I'm just happy to see our plan go forward.... Despite the Orwellian doublespeak ... it looks pretty identical to the deal that Ernie Eves" came forward with.

What's a public hospital? Until now, the hospitals have been built with capital grants from the government, with additional fundraising in the community. We raised \$21 million in Windsor. The hospital is owned publicly; it's paid for publicly through capital grants, not out of the operating budgets. It is operated as a public service, not as a commercial entity. We've seen in the United States,

with the Hospital Corporation of America, where the corporation had to agree not to offer the executives incentive bonuses as part of the billion-dollar settlement for fraud.

The Chair: Thank you, Mr Longmoore. Your time has expired.

Ms Smith: If I could just respond.

Mr Longmoore: Could I just finish?

The Chair: No.

Mr Longmoore: I just have three more lines.

The Chair: Somebody else will be asking you a question, and certainly you can use your time.

Mr Longmoore: OK, you'll let me finish?

The Chair: I'm sure you'll get your chance.

Ms Smith: You'll have a chance to talk to the authors of private hospitals right there. Feel free to address Mr Klees.

Interjection.

Mr Klees: Absolutely, they're the same.

The Chair: I had extended your time by a minute just to let you go at that point.

Mr Klees, the floor is yours.

Mr Klees: I want to thank you for your clarity on the issue of the P3. The fact is that I will take issue with you. We don't agree. We're not on the same page on that, because I happen to believe that there is a role for the private sector. Having said that, though, what you're addressing, I think, is something along the lines of a credibility gap that exists between what the Liberals were saying when they were on the campaign trail and when no doubt many of your supporters helped get these folks over here elected—you believed them, didn't you? You believed that they were going to shut them down and that they were going to ensure that hospitals would be publicly funded.

Mr Longmoore: The people of Brantford did; they believed.

Mr Klees: They believed, yes. How do they feel now?

Mr Longmoore: Who's the MPP for Brantford? Ask that person, I guess.

Mr Klees: I'll tell you what we've been hearing across the province as we've been travelling. It didn't matter if it was Sudbury or Ottawa. It doesn't matter where we are. People are very, very disheartened because they see one more broken promise here in this bill—actually, many broken promises. It has been referred to as a dramatic bill. It's actually a very scary bill to most people in the province, when they see what is here.

Let me give you an example of what they're trying to hide. We were in Ottawa yesterday. Of course, the parliamentary assistant was defending the fact that it is not a P3 hospital that is going in there. So a motion was made. Ms Martel made the motion, asking the Liberal government to table the contract. Mr McGuinty ran on the platform of being open, an open government. A very quick way for people to determine whether this is a P3 or not is to see the contents of the contract. Surely, if it's a publicly funded hospital, then the public should have access to the agreement. Would you agree?

Mr Longmoore: I agree.

Mr Klees: Well, do you know what happened? Every single Liberal member on this committee voted against doing that. Can you possibly imagine why? I think you'll draw your own conclusions. We on this side actually can't believe for a minute what Minister Smitherman is telling us he'll do by way of fixing this, because we have seen very little evidence that they will do what they say they're going to do. So our caution to you—and by the way, I moved a motion that incorporated specific wording to protect collective agreements. In fact, it was wording lifted right out of presentations made by the CUPE local in Sudbury. It was voted against—by whom?—by every single Liberal member of this committee. I tried to table that same motion today, thinking that there might have been a change of heart, but it was ruled out of order.

So, folks, beware. There's something at work here. We're not sure what, but we do know this: It's not going to be in the public interest. It concerns us gravely.

I'm going to give you the rest of my time to read the rest of your lines.

Mr Longmoore: Thank you, Mr Klees. Welcome back to Essex county.

Mr Klees: Thank you.

Mr Longmoore: There is no for-profit consortium in charge of great sections of the hospital. We do have Tim Hortons doughnuts, which is a wonderful health message to send to the people of our community. There have been attempts to diminish this by privatizing some services such as laundries, food—the wonderful food that comes in frozen from London. In some cases, they have succeeded; in others, privatization of services has been stopped. We have actively fought to keep all hospital services non-profit. In no case has the privatization of the hospital services been as deep or as broad as is now being proposed.

Look across the United States. Forget David Osborne, the new guru of the Liberal Party. Look at the United States, at what has happened, the mess of the private hospital system. We don't need that. It's coming. It's coming to this country. Once we open the hospitals up, they're all coming over. Great-West Life is already in the United States. They'll come back and they'll be competing to carve up the hospital industry, and we will have lost what you allegedly are trying to enshrine in this document, Bill 8.

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The Chair: Ms Martel.

Ms Martel: Thank you for your comments. It will be no surprise to anybody that I'm going to focus on the P3 hospitals as well, which I've tried to do during the course of these hearings. Thank you very much for raising what Mr Baird said, because, actually, that was going to be the first thing I did, just to make it very clear. Let's be clear, Mr Baird was in cabinet essentially from 1999 on—I can't remember if he was in before that—and was at the table when the P3 model was being developed. So he very clearly understands what's going on here and where the government was heading. So if Mr Baird comes

forward and says in Ottawa, as he did on the day Mr McGuinty tried to pretend this was something different, that this is exactly the same, then I think Mr Baird is exactly right: It is exactly the same.

What's interesting about the announcement made by Mr Smitherman on the 27th was that he didn't say anything about publicly financed hospitals, and I didn't hear Ms Di Cocco talk about that in terms of her commitment. That's critical in this issue: publicly financed.

What the Liberals are involved in now, which is exactly what the Tories were involved in, is private financing of these hospitals, which breaks with tradition in Ontario, where the public and public dollars financed hospital renovation, hospital construction. Why? Because public dollars are dollars that are well spent. There is not a profit motive, and there are also no additional costs with respect to borrowing. Government gets the lowest borrowing rate. So as the private sector finances this, we, through the mortgage, pay a higher cost for interest.

We also pay a higher cost for the mortgage, because the private sector isn't doing this out of the goodness of its heart. The private sector is in this game to make a buck; maybe it's 15%, maybe it's 20%, but that's an additional cost that gets added on to the mortgage. In this case, the mortgage is going to be paid for out of the operating budget of the hospital. Taxpayers' dollars that should be in the operating budget to go into patient services instead get diverted to paying a profit to the consortiums that are doing this construction. That's what I find so offensive about these deals, and that's what I find offensive when I listen to the Liberals talking about how this has changed, because it hasn't. The private sector is at the table, and the private sector is going to benefit by getting public money that should be going into patient care and patient services.

The Liberals should be living up to their election promises, because Mr McGuinty was very, very clear: He was going to cancel P3 hospitals. And here we are, moving down the same road as the Conservatives before us. He was also very clear that he was going to stop the private MRI and CAT scan clinics and put that technology back into the public system, and that hasn't been done either.

It's interesting that it was a member from this community, Ms Pupatello, who talked about poaching and why the private clinics were so bad, because people were going to be poached out of the public system. That's exactly what has happened, and those things are still operating.

When you look in the preamble, there's also a reference to home care and a commitment to home care, but this government is also not doing anything about ending competitive bidding in home care, ending the privatization in home care so that money could go into patient services instead of profits.

So I appreciate that you talked about privatization today and reminded the Liberals about their promises, because I think people voted for change. It's clear to me there's a different government and people haven't seen any change.

There's a real contradiction—that's the politest term I can use—between the preamble, which talks in glowing terms about support for medicare and publicly funded services, and what is actually happening. There's a huge disconnect, there's a huge gap. I'd just like the Liberals to live up to their election promises in this regard. I think the public would be much better served if they actually did that.

Mr McGuffin: Absolutely.

The Chair: Thank you for coming today. We certainly did appreciate your input.

CHATHAM-KENT LABOUR COUNCIL

The Chair: Now if we can move on to the Chatham-Kent Labour Council, represented today by Bill Steep, who is the vice-president. I understand you'll be joined by Gary Watson, the treasurer—moral support in the back, perhaps.

Mr Bill Steep: That's what I was looking for.

The Chair: You've got 30 minutes, Mr Steep. You can use that any way you like. At the end of your presentation, we'll use the remaining time to ask you questions, and we'll share that time evenly. The floor is yours.

Mr Steep: I won't be 30 minutes.

The Chatham-Kent Labour Council represents 10,000 people in this community in various occupations. We have long been involved in the economic and social issues of our community, such as health care, and welcome the opportunity to speak to you today.

Bill 8, the Commitment to the Future of Medicare Act, introduced by the newly elected Ontario Liberal government last November 27, 2003, aims to establish an Ontario Health Quality Council, replace the existing Health Care Accessibility Act with somewhat modified provisions and provide for accountability in the health services sector.

We have serious concerns with this bill as it is currently drafted and intend to proceed through its major sections to point out its weaknesses and offer our views for change.

The preamble to Bill 8 recognizes that our system of publicly funded health care services reflects fundamental Canadian values and that its preservation is essential for the health of Ontarians now and in the future. It confirms an enduring commitment to the five principles of medicare: administration, comprehensiveness, universality, portability and accessibility, as currently codified in the Canada Health Act.

Unfortunately, there is little actual legislation that provides any significant new initiative of these principles. Although the preamble commits the government to support the prohibition of two-tier medicine, extra billing and user fees, a closer examination of the legislation shows it fails to entirely close such options. While the preamble recognizes that pharmacare for catastrophic drug costs and primary health care based on assessed needs are central to the future of the health care system,

there is nothing in the draft legislation which directly addresses either of these concerns.

The Ontario Health Quality Council, outlined in part I, section 1 to section 6, of Bill 8 is supposed to monitor and report to the public on access to publicly funded health care services; health human resources in publicly funded health care services; consumer and population health status; and health service outcomes—and to support continuous quality improvement.

It is our belief that this section is, to say the least, poorly drafted. Given the preamble's commitment to the principles of the Canada Health Act, it is disturbing to find that the Ontario Health Quality Council does not include reporting on the extent, or otherwise, that the Ontario health care system complies with the principles of public administration, comprehensiveness, universality and portability contained in the Canada Health Act. Further, it is not required to report on issues relating to two-tier medicine, extra billing and user fees. Each one of these issues is fundamental to the health care system and of primary importance to the public.

The council is to be composed of between nine and 12 members, all of whom are to be appointed by cabinet. We are compelled to ask, where is the democracy in this process? Where is the transparency? For all the public knows, representatives from the private for-profit sector could be appointed as a major step toward eroding our public not-for-profit system. It is our strong view that for-profit providers, given their blatant conflict of interest, should be excluded from the council.

We believe it is essential that the people of Ontario exercise their democratic control over their health care system through democratically elected boards reflecting and inclusive of various community constituencies, service users, patient advocates and health care staff. Decision-making should be open and transparent.

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Should the council have representative and inclusive criteria and elections for its makeup, there is a further issue that should be dealt with. While the council is required to deliver a report on the health care system on an annual basis to the public and to the minister, it is specifically prohibited from making recommendations as to the future course of action to be undertaken. A good deal of the value of such council is thereby thwarted by its inability to make recommendations.

We support an elected, inclusive and representative council that is free to make recommendations on the steps to be taken to ensure the future of Ontario's medicare system.

Opting out and extra-billing: Bill 8 extends the prohibition against extra-billing by eliminating the right of physicians and other designated practitioners to opt out of the Health Insurance Act and receive direct payments from patients for insured services up to the OHIP maximum. These provisions in subsection 9(2) seem to strengthen the prohibition on extra-billing and opting out, yet a further section of the bill, subsection 9(4), contains language that may well open up the possibility of the

government itself, through regulation, allowing extra-billing and opting out.

We support a ban on extra-billing and opting out and the act should specify such.

I personally don't have any examples of extra-billing in our community. I think we're probably lucky in that regard.

Queue-jumping: Here Bill 8 proposes a new section, 15, to limit the ability of individuals to jump the queue. An insured person cannot pay or confer a benefit in order to receive a preference in having access to insured services, nor can a practitioner charge or accept money for granting any such preference. In other words, a person cannot be charged money to receive a particular test or procedure in advance of another person.

The main problem with this section is that it prevents queue-jumping for insured services only. Yet more and more pressure seems to be forthcoming, due to financial considerations and private interests, to delist services. As the list of medically listed services is restricted, this provision would not be applicable and those seeking delisted services, which would not be protected from queue-jumping.

The major threat, therefore, is not the occasional queue-jumping abuse but rather the ongoing shift from public to private, for-profit health care services. It is our view that this shift must be stopped and reversed. The newly elected Liberal government campaigned against privatization of health care and should follow through on their commitment to the people of Ontario. Currently, the most insidious form of this privatization is what is termed public-private partnerships, or P3s. The P3 projects of the previous Conservative government, from Brampton to Ottawa and others in the planning stages, should be immediately halted, along with the delisting of services.

It has been estimated that such private models can be expected to cost at least 10% more than their public sector equivalents. So, in addition to the evidence from other such experiments in Britain and Australia that suggest P3 hospitals would include a deterioration of hospital services and diminished accountability, Ontario simply cannot afford a private health care system. Making the operation of a hospital private but keeping the ownership public through a mortgage doesn't substantively change the private, for-profit character of P3 organizations.

Already, private stand-alone clinics such as MRIs and CTs operate outside the public medicare system and drain money from it through third party billings, such as WSIB, third party insurance, and thereby deprive hospitals of lucrative revenue. Further, such private clinics poach scarce reserves of skilled staff from the public system. They further enable queue-jumping for so-called medically unnecessary services.

Home care provides a further example of the negative impacts of privatization. The privatized delivery of home care through competitive bidding adopted by Ontario is redirecting precious health care monies out of patient care and into ballooning administrative costs, and this

despite sending labour costs—people's living standards—into a nose-dive. Ontario's home care system is rife with duplication, inability to utilize staff efficiently, additional expenses surrounding tendering requests for proposals, preparing bids, evaluating proposals, monitoring and, of course, profit-taking.

Block fees: Many physicians across Ontario have charged patients for uninsured services by charging an annual block fee. Typically, such services include telephone advice, renewal of prescriptions by telephone, completion of various forms etc. Such block fees have to date been largely unregulated, although there are certain guidelines outlined by the College of Physicians and Surgeons of Ontario.

The proposals in Bill 8 specify that the government, not the physician, will determine whether, and under which circumstances, block fees can be charged. It is our view that block fees should be banned. Block fees are but another mechanism to erode the publicly funded health care system and should not be allowed in regulations or anywhere else.

Ontarians are already confronted with a reduced scope of services covered by public medicare, and as the burden is shifted to individuals, the unpopularity of such fees will increase. In addition, to allow fees in regulations will make their usage widespread, thereby negatively impacting labour management negotiations by adding an additional cost factor.

Accountability agreements and compliance directives: The most important, controversial and potentially dangerous sections of Bill 8 are contained in part III, sections 19 to 32. They cover the powers of the Minister of Health to compel persons to enter into accountability agreements or compliance directives. These provisions have been drafted in such a broad manner as to give the minister unprecedented power to require individuals and organizations to comply with whatever the minister desires, potentially including the overriding of legal collective agreements and other negotiated agreements. This constitutes a fundamental affront to the people's rights in a democratic society.

Under the provisions as currently drafted, the minister can direct any health care provider or any other agency or person to "enter into an accountability agreement with the minister and with any one or more persons, agencies or entities." Even a trade union, under the broad definition of a health care provider, could qualify to enter into such an accountability agreement.

Not only is there little limitation on the minister's power under such circumstances, but there is also little explanation in the proposed legislation as to what accountability actually consists of. As defined in Bill 8 subsection 19(a), an accountability agreement is an agreement establishing "performance goals and objectives ... service quality, accessibility of services ... shared and collective responsibilities for health system outcomes ... value for money ... and other prescribed matters." In short, an accountability agreement can cover anything the government wants it to cover.

We are opposed to sweeping powers being given to the minister and such ill-defined accountability agreements. Indeed, throughout the bill, the powers granted to the minister are too broad, too open-ended. It is often unclear as to specifically what the directives are about, what their content is and to whom they will be directed. As a person proceeds through the bill, he or she increasingly gains the impression that the directives of the minister can be to anyone for virtually any reason.

Further, according to section 20 of Bill 8, the minister, in exercising his or her powers, is to "be governed by the principle that accountability is fundamental to a sound health system" and is thereby to consider a list of matters such as fiscal responsibility, value for money, a focus on outcomes and any other prescribed matters. We are very much in favour of a high-quality health care system and desire value for money and fiscal responsibility as much as anyone, but terms such as these are all too often used as code words in the for-profit sector. As a representative of the labour council, we are committed to public medicare and are opposed to such language if it is meant to advance a privatization agenda.

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The sweeping powers of the minister and breadth of the directives is further revealed in sections 26, 27 and 28 of the bill. Section 27 enables the minister to unilaterally change a person's "terms of employment," and if this isn't bad enough, "the change shall be deemed to have been mutually agreed upon," and further along, "the change does not entitle the person to any sort of payment or compensation, despite any provision to the contrary in his or her contract or agreement of employment."

Section 28 gives additional unprecedented powers to the minister enabling him or her to reduce funding, vary funding or discontinue any term of a contract or agreement of employment. Again, such dictated changes are deemed to have been mutually agreed upon.

These sections should be repealed in their entirety. They are in opposition to democratic practices such as elections, transparency, such as public reporting on finances, and increased community control and genuine accountability.

Under the provisions of part III of Bill 8, there is a distinct possibility of severe repercussions for trade unions and collective agreements. Trade unions and employers could have a directive to address certain cost-saving measures, for example, through collective bargaining. Should they fail to do so, they could face an order requiring them to reduce wages or benefits or both. Alternatively, they could be confronted with an order to repeal their no-contracting-out language or their successor rights clause.

In the name of value for money or fiscal responsibility, hospitals and health care employees could be compelled to consolidate operations such as laundry or food services and change their collective agreements to facilitate such changes. An alternative avenue open to the minister would be to simply order a compliance directive requiring collective agreement protections to be modified or overridden.

Admittedly there are counter-arguments to the misuse and unfairness of such a sweeping exercise of ministerial fiat, but why does the bill take us down this road when it is so obviously as undemocratic as it is unnecessary and wrong-headed? Why should the vast majority of Ontarians who value public medicare have to resort to counter-arguments to address the potential threat to free collective bargaining?

While the motivation of the government is not entirely clear, part III of the bill can only be seen as an attempt to grant the minister virtually unlimited power to unilaterally dictate fundamental changes in the health care system without procedural safeguards or democratic input, far less anything approaching transparency. Despite the comforting words of the preamble, Bill 8 is more reminiscent of the Conservatives' omnibus Bill 26 than it is of the five principles of the Canada Health Act.

It even takes the further step in section 30 of seeking to insulate itself from legal liability arising from public opposition in the form of actions taken in connection with accountability agreements or compliance agreements. No one will be allowed to take legal action against the minister or the crown under the provisions of this bill upon its passage. At the same time, the government is free to prosecute anyone not complying with an order by the minister.

The powers and penalties in the bill are all stacked on one side, and it is not on the side of those who want democratic representation and transparency in a medicare system supposedly designed for them. Unfortunately, we are left with little alternative but to call for a complete withdrawal of this section of the bill.

In conclusion, one might have hoped this bill would explicitly prohibit two-tiering and so-called medically unnecessary procedures. Accessibility should have been strengthened and assured with specific attention paid to marginalized and equity-seeking communities and those in communities that are geographically remote. There would have been some recognition that for-profit provision is a giant step back from accessibility, as can be clearly seen in the American context, where millions of people have no medical coverage whatsoever and millions more are inadequately covered.

One might also have expectations for provisions on portability to have been included. Currently, Ontario is not covering services for people in other provinces, yet virtually all Canadians travel from different parts of the country and at some point should enjoy the full coverage of that province.

Given the preamble, one would have also reasonably expected to find provisions on pharmacare and home care.

In regard to public administration, we can only once again raise our concern about the lack of democratic participation and transparency, as opposed to open-ended, top-down sweeping powers to the minister. This is particularly troubling in the context of the province's debt and the consequent cries for restructuring and efficiencies.

Let us be clear: Moving to sell assets, such as TVOntario and the liquor board, won't solve the problem of a structural deficit, but more revenue will. It is a one-shot deal postponing the problem until next year.

Privatization, in the form of P3 hospitals or whatever, is not reinventing government. It's a path rejected by the voters of Ontario, and all the evidence from other jurisdictions tells us it will lead to worse public services.

We urge the government of Ontario, in light of our comments, to reconsider this bill. Thank you for the opportunity to participate in this important discussion.

The Chair: Thank you, Mr Steep. You've left us about six minutes. That would be about two minutes each. We're going to start that with Mr Klees.

Mr Klees: Thank you, Mr Steep, for your presentation.

You're well familiar with agreements. You read legal agreements all the time. I wonder how long it took you, after reading Bill 8, to figure out that this is a major smokescreen.

Mr Steep: It's an awful lot to digest—the first couple of sittings of going through this—but eventually I have come to the conclusion that our collective agreements could be in jeopardy by the way it's written.

Mr Klees: There's only one other piece of legislation in this country that I think comes close to the kind of heavy-handedness, and that's called the War Measures Act. I'm not sure what Mr Smitherman's state of mind was when he agreed to bring this forward.

You make reference, for example, to the fact that in this bill, no one will be allowed to take legal action against the minister or the crown if somehow they don't like what the minister has done by way of his unilateral action. What's interesting is—and you'll hear from the parliamentary assistant—that the minister has agreed to make all kinds of amendments.

We have an outline of what those amendments will be. It's interesting that there are references to all kinds of clauses, but that one's still there. So the minister has made no attempt, in spite of everything that this committee has heard, about the offensiveness of this part where the minister can say: "I'm going to unilaterally tell you what the agreement's going to be, and you are going to be deemed to actually have sat down opposite and signed off on it. And by the way, if you were hurt by it, you'll have no legal right to claim compensation."

Does that sound like the War Measures Act to you, sir?

Mr Steep: I don't know whether it goes quite that far, but certainly it's an unfair and unjust way of putting it.

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The Chair: Ms Martel.

Ms Martel: Thank you for coming today to make the presentation.

I just wanted to deal with that section as well. I don't want to use the term "War Measures Act," but there is a contradiction here, and I guess the government's going to have to deal with this and explain it to the public.

Clearly, we have seen some proposed areas of change today—and Mr Klees is quite correct, as I had picked it up as well: There is no change in the section that says, “No compensation shall be payable by the crown, the minister, or any other person, entity or agency for anything done or purported to be done under any provision of this part or the regulations.” So, the minister has essentially no liability.

Yet, when I go to the penalties for other people, while those have been changed, because they were very excessive and aggressive, the fact of the matter remains there are significant penalties that remain for everybody else who is not responsible. So we see that there will be reductions of penalties from maximums of \$25,000 and \$50,000 and they may be changed to \$10,000 and \$25,000. It looks like, “penalties associated with mandatory reporting (queue-jumping)” for example, will “be reduced to a maximum of \$1,000 per offence.”

I guess the point that has to be made is that the minister, through the bill, is making everybody else accountable, and if they’re not, there are some penalties. The accountability with respect to the minister is very unclear, and there are certainly no penalties that are allowed. If accountability is a two-way street—and we’ve heard a lot about that—I don’t see that happening on the part of the government. Do you have any reflection about that?

Mr Steep: That was my concern too, but I was certainly also worried about the fact they could make you change your collective agreement and if you didn’t comply, they could fine you. I personally don’t know too many local unions or individuals that could afford any kind of fine in those measures.

The Chair: Ms Smith.

Ms Smith: Thank you, Mr Steep. Are you aware that the minister wrote a letter to Mr Ryan of CUPE on Monday following his statement to this committee?

Mr Steep: I was just given a copy of a letter. I only had a chance to go over it very quickly. I did notice some of the changes but I didn’t read it in depth.

Ms Smith: Just so we’re clear, the minister did say on Monday that this piece of legislation would not apply to trade unions, nor would it affect collective agreements. Again, today he’s provided this committee with a framework of some of the potential changes to the legislation, which includes changing “health resource provider” ... to exclude solo physicians, group practices and trade unions. These entities would not be required to enter into accountability agreements under this legislation and therefore not subject to any provisions of part III.” I think that goes some way to calming your fears. I would have expected that through your organizations you would have heard that by now, because we’ve had numerous presentations and we’ve made this point numerous times this week, but we’ll continue to make it.

Mr Steep: Unfortunately, I just got it five minutes ago.

Ms Smith: OK. You mentioned that you were concerned about the focus of some of the issues that would be included in the accountability agreement, including

fiscal responsibility. I do note, however, that in section 20 we talk about things like clear roles and responsibilities, shared and collective responsibilities, transparency, quality improvement, public reporting, consistency and trust. Do you have any concerns about any of those types of issues being included in an accountability agreement between a hospital board and the ministry?

Mr Steep: I think those things should be included, absolutely. I think accountability and transparency are the most important things. I think we need to look at what’s going on and be able to evaluate it for ourselves.

Ms Smith: That’s exactly the point of accountability agreements. Would you agree with me, sir, that accountability agreements between hospital boards and the ministry are a good thing?

Mr Steep: If they have the proper wording, absolutely.

Ms Smith: That’s great. Thank you very much.

The Chair: Thank you, Mr Steep. Your 30 minutes are up. Thank you very much for the presentation. We did enjoy it.

LEAMINGTON DISTRICT MEMORIAL HOSPITAL

The Chair: We now go to a representative of the Leamington District Memorial Hospital. Cole Cacciavillani, the chairman of the board, is with us. Thank you for joining us today. You’ve got 30 minutes allotted for your presentation. You can use that any way you so choose. Any time that is remaining at the end of the presentation will be allocated for questions among the three parties. The floor is yours.

Mr Cole Cacciavillani: Good afternoon. My name is Cole, Cacciavillani and I am a local businessman and voluntary chair of the board of directors of Leamington District Memorial Hospital, a hospital with an excellent record of efficiency and balanced budgets over the last 10 years.

I am pleased to have this opportunity to submit our comments and serious concerns about Bill 8 this afternoon, because I am speaking on behalf of all the members of our very dedicated board of directors. They are all outstanding citizens volunteering their valuable time to serve on a very demanding board, not for any political gain or financial reward, but for the satisfaction that we have ensured the best use of our tax dollars for those who fund us and provide the best possible health care for our community that has elected us. We have acted and will continue to act on their behalf.

Let me first congratulate the government for introducing the following overarching principles, which are the intention of Bill 8, that our board is fully supportive of: ensuring accessibility to the health care system and enhancing accountability to Ontario taxpayers. Our board sees that these are the two fundamental principles which motivate every member of our board to dedicate our time and energy, year in and year out. I would like to submit that these would also be the founding principles for all

independent local voluntary hospital boards in this great province of ours.

We commend the government's commitment to medicare and accessibility as intended by Bill 8. Our board wants to indicate our support for the following key principles of Bill 8: establishing a health quality council, embracing the five key principles under the Canada Health Act, adding accountability as a sixth principle, setting a framework for accountability agreements, and strengthening provisions governing medicare.

However, our board also has serious concerns about a number of the provisions found in part III of the bill, dealing with accountability. The bill is unnecessarily one-sided. It focuses exclusively on how to make health care providers accountable to the government, yet is silent on the government's obligation with respect to ensuring the provision of health care. For example, it allows the minister to unilaterally terminate accountability agreements or change a directive at any time, and absolves the ministry and the crown of any and all liability.

Neither the bill nor the process for agreements nor the actions of the ministry to date lay out a clear vision and direction for health care for Ontario. We believe hospitals should be accountable and plan for the future, but we believe that this cannot be done in a vacuum.

One of the requirements under the Canada Health Act is access to services. Bill 8 may expose the government to charter challenges, as it does not provide for timely access to services. Access to services may also be reduced by some of the provisions in part II of the bill prohibiting hospitals from paying physicians and practitioners for insured services.

Therefore, the purpose of this submission today is twofold: to convey our board's support of ensuring and enhancing accountability and accessibility to quality health care on one hand, but on the other hand to urge the government to make extensive amendments to Bill 8 by removing those components of the bill that, if enacted and implemented, will actually reap the opposite effect of the principles of accountability and accessibility.

Our board strongly believes in accountability. Our board believes we are accountable to both the government and to the communities we serve. The track record of the Leamington District Memorial Hospital has demonstrated how our board has ensured that taxpayer dollars have been spent wisely while ensuring our communities have the best possible access to quality medical services that are appropriate for a community of our size. Our board has demonstrated that we have been leaders in accountability by engaging in all categories of auditing by external bodies: financial audits, radiation safety inspections and hospital accreditation surveys etc; by participating in the comprehensive hospital-specific Ontario report card series, which is the only one in the country; and by publication of our own hospital's corporate balanced scorecard in the last five years and annual community reports.

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Our hospital's operation efficiency and high productivity, as demonstrated by various performance indi-

cators, has enabled the Leamington District Memorial Hospital to increase accessibility to services by introducing more than 20 new programs and services in the last seven years, with a history of balanced budgets while adequately maintaining our working capital. Our record demonstrates our board's commitment to the taxpayers and communities we serve. Therefore, let me make it absolutely clear that our board strongly supports the principle of accountability, and we want to do our part to ensure that this happens and that it can be enhanced.

However, we do take issue with the way in which Bill 8 attempts to enhance accountability. First of all, we believe that Bill 8 must be amended to make accountability provisions fair and effective. In order for accountability to be fair and effective in the provision of medicare, there ought to be a shared accountability between providers and government.

We believe Bill 8 as presently drafted fundamentally reduces government's accountability by removing the requirement for the minister to act in the public interest, as defined by the Public Hospitals Act. Public interest is defined as any matter related to:

“(a) the quality of the management and administration of the hospital;

“(b) the proper management of the health care system in general;

“(c) the availability of financial resources for the management of the health care system and for the delivery of health care services;

“(d) the accessibility to health services in the community where the hospital is located; and

“(e) the quality of the care and treatment of patients.”

By removing the requirement of the minister acting in the public interest, the minister is less accountable to the public in ensuring the accessibility to health care services in the community where the hospital is located. Consideration of the public interest is very important in protecting medicare in Ontario, which is one of the objectives of Bill 8. Removing this requirement significantly reduces the government's accountability to the people of Ontario.

Section 21 outlines the power of the minister in directing a hospital to sign an agreement that has not been negotiated or agreed to but is unilaterally imposed. Forcing hospitals to sign performance agreements is contrary to the fundamental tenet of contract law, which stipulates that parties must enter into a contract freely. Such unilateral imposition of agreements not only effectively silences the voice of the community in meeting fundamental decisions about hospital services in their community, but also undermines local governance of public hospitals. We believe that accountability agreements must be negotiated and must be shared.

This leads to our second serious concern. As I shared with you earlier, the main reason why volunteers serve the board at the Leamington District Memorial Hospital and, I believe, every hospital board in Ontario, is to ensure that quality medicare is accessible to our com-

munity. Our motivation to serve is to make a difference for our community.

Bill 8, as it is presently drafted, seriously threatens and erodes the role of independent local voluntary governance structure. We believe Bill 8 fundamentally undermines the role of independent local voluntary hospital boards in two significant ways. First, it usurps the role of the board in representing their local community needs by imposing a non-negotiated accountability agreement with the hospital. Second, it fundamentally undermines the governance structure of public hospitals by having the power to make an order affecting an employee of the hospital—I'm referring to sections 26 and 27. Hospital CEOs are accountable to the board for their performance, and the board is responsible for the conditions of the CEO's employment. This direct intervention approach has been rejected by the BC provincial auditor in its review of BC performance agreements as "detrimental to governance of the organization" and "ineffective in improving performance." I refer you to subnotes 1 and 2.

We have grave concerns with this legislation as it is currently drafted. It may actually decrease accountability to local communities by fundamentally undermining the role of local, voluntary governance of public hospitals in communities across Ontario. This will irrevocably alter the relationship between hospitals and their communities.

I'm sure most of the people in the province recognize that one of the strengths of the Ontario hospital system is its local, independent, voluntary boards. I personally believe that if part III of Bill 8, accountability, is not extensively amended, you will see resignations of many fine Ontario citizens from their local hospital boards, and recruitment of qualified voluntary board members will become increasingly difficult. Therefore, while our board supports accountability and wants to enhance it, we believe Bill 8 must provide for government accountability as well. The Ontario throne speech in November 2003 stated: "Your new government understands it can only hold others to a higher standard if it subjects itself to the same standard." We believe the bill must include the requirement for the minister to act in the public interest in order to ensure "accountability of health services in the community where the hospital is located."

We also suggest that compliance directives in Bill 8 are inappropriate in the context of a negotiated agreement. We cannot support any provisions which allow the minister to make an order that may result in a material change in a person's employment, and believe these provisions must be removed.

In addition to my comments on accountability, I also wish to comment briefly on the two remaining parts of the bill: the health quality council and accessibility.

Our board supports the establishment of a health quality council for Ontario and believes that it could play an integral role in enhancing accessibility and accountability. We suggest the effectiveness of the council could be strengthened by: an independent council which reports directly to the Legislature, as described in the Liberal campaign platform and the speech from the throne;

allowing representatives from health care system provider organizations to ensure the council has significant and sufficient expertise; providing the council with the power to monitor and report on the quality of and accessibility to publicly funded services by building on evidence-based information in studies undertaken by such bodies as the Institute for Clinical Evaluative Studies.

Accessibility: We believe that any initiative to enhance accessibility to publicly funded health care services must include a commitment to ensuring that there is a mechanism by which to prescribe and monitor wait times. As currently drafted, Bill 8 does not appear to address this very critical issue.

There is also real concern, in the accessibility section of the bill, part II, that there may be a prohibition on payment of hospitalists, lab physicians and other types of physicians to whom hospitals make direct payments. Paradoxically, this provision may have the effect of reducing access to health care services.

In conclusion, our board endorses the effect to ensure accessibility and enhance accountability but cannot support Bill 8 as currently drafted. Bill 8 must be extensively amended to ensure communities have a say in the services they receive and in how their local hospitals are managed; to ensure that responsibility for accountability and actions that are taken are in the public interest; to ensure that both providers and government are held accountable to Ontarians for health care they receive; to ensure that accountability agreements should be between the board, as representatives of the hospital and the community, and the minister as a representative of the government and the taxpayers; to ensure that Ontarians have access to the health care services they need in a timely way.

We believe, because the required amendments are extensive and have not yet been tabled, that it may be prudent for a committee to consider another round of consultations on this topic after the amendments are known.

Thank you for listening to me and our board of directors.

The Chair: Thank you, Mr Cacciavillani. You've used up 15 minutes, which leaves us with 15. We're going to start with Ms Martel.

Ms Martel: Thank you for being here today. I'm going to focus on page 5, the three points that you make at the top of the page. The first says, "We believe the bill must include the requirement for the minister to act in the public interest." We received a document from the minister today, via the parliamentary assistant, which outlines some of the areas the minister wants to make changes in. I want to be clear that we don't have the wording of the amendments. What we are dealing with are the suggested areas for change. So it does appear that the minister wants to include public interest, but he wants to do that in the preamble of the bill, which makes no sense to me whatsoever. Frankly, in this bill, the preamble has a huge disconnect with the rest of the bill. It's

a statement of important and valuable intentions, but the rest of the bill does very little to support the preamble.

1550

So would you agree that it would make much more sense, if we're talking about public interest as we do in the Public Hospitals Act, that that should go into part III, which is the section that deals with accountability agreements?

Mr Cacciavillani: Absolutely. Accountability has to be shared both ways. It has to be part of the bill.

Ms Martel: Two points: We had hoped that what the minister gave back to us today would give some comfort particularly to hospital boards, that have been coming forward to express concerns about accountability agreements. My concern is that I don't see anything here that's going to give anybody much comfort. I appreciate that you don't have this in front of you, so I will read this into the record as quickly as I can.

You also suggest "that compliance directives in Bill 8 are inappropriate in the context of a negotiated agreement." Let me tell you that the proposal that has come back from the minister is that the minister would "include notice and other due process provisions, including time frames for notice, to address development of accountability agreements, issuance of compliance directives and orders (eg discussion process, meetings, exchange of documents/information, representations that the minister has to consider before issuing a compliance directive or an order)." Does that sound to you like any kind of negotiated agreement?

Mr Cacciavillani: No, it doesn't, and the words "directive" and "order" don't lend themselves to a negotiated agreement either.

Ms Martel: OK. So your concerns would clearly still remain in that regard.

Let me deal with the next one: "We cannot support any provisions which allow the minister to make an order that may result in a material change in a person's employment," namely, the CEO, whom you have responsibility for as a board. Here's what the minister has come back with: "Include range of remedies directly in legislation that could be issued in a compliance directive or an order to address non-compliance (eg audit, budget review, etc). CEO compensation clawback or any other financial remedies to be applied to a CEO as a last resort only after all due process has been exhausted and in exceptional circumstances." It seems to me that the minister still has the power to deal with CEO compensation, ie, in terms of a clawback. Would that be your understanding of what I just read?

Mr Cacciavillani: Yes, and I'm not so sure what the difference is between what you just read and what those powers are right now.

Ms Martel: Neither am I. This is part of the reason I raise this. As I look at what's here and reflect on what we've heard, I don't think the minister has given very much comfort to very many people, so I suspect he's going to have to go back and have another stab at this.

Mr Cacciavillani: Yes. I would also say that everything the minister has said so far that I'm aware of is only in principle. They're not actual amendments to the act. So I would stress my last point, that since they're only in principle, I would still urge the committee to let the public at large take a look at the amendments as tabled. I believe they're going to be tabled at some time in March.

Ms Martel: March 9, yes. Great. Thank you.

The Chair: Ms Smith.

Ms Smith: Thank you, Mr Cacciavillani, for coming to speak to us today. As you know, we've brought forward Bill 8 after first reading in order to get input from the public. We've certainly had a lot of input from members of the public over the last four days, so we appreciate your being here to provide us with yours as well.

I was really pleased to see on page 1 your commitment to accountability and the commitment of your hospital to enhancing accountability to the taxpayers of Ontario. Certainly that's the intention of this government as well, so I think we're working from the same page.

I recognize that you've raised a number of concerns, some of which I think will be addressed in the revisions this government is proposing to bring, as Ms Martel noted, in the framework we've provided.

First off, though, I would like to just note that you are a member of the OHA, I assume.

Mr Cacciavillani: Yes, we're a member hospital.

Ms Smith: And you are aware that we have had a number of meetings and negotiations, including the minister himself, discussing some of these changes?

Mr Cacciavillani: Absolutely.

Ms Smith: So you are aware that the governance of your hospital is no longer in jeopardy, as we have confirmed that in future the accountability agreements will be between the board of the hospital and the ministry, not the CEO.

Mr Cacciavillani: I agree, but as I told Ms Martel, it's still only in principle. The minister has only said these things in principle. They're not amended to the act yet.

Ms Smith: The minister has made a commitment to bring those amendments forward for the act. Do you accept the need or the benefit of having accountability agreements between boards and the ministry?

Mr Cacciavillani: As long as they're shared accountability and they're negotiated. The problem with unilaterally having an agreement in place—somehow, the ministry has to take responsibility as well.

Ms Smith: When Ms Martel went through, briefly, some of the proposed changes, one of the things we have in the proposed changes is that we would "include notice and other due process provisions, including time frames for notice, to address development of accountability agreements." Does that, to you, speak to imposition of an agreement, or does the development of an agreement speak to you of some give-and-take on both sides?

Mr Cacciavillani: I think it speaks to the development on both sides.

Ms Smith: Section 21 is what I just addressed. I've addressed your concerns, I think, about the board and about direct—I did want to talk to you a little bit about your concerns on page 4 with respect to the auditor's report in BC. In what way do you see the BC legislation being similar to what's being proposed here?

Just so I can be a little clear, when I read through the footnote that you've quoted, it would seem to me that in the BC situation there is a much more direct relationship between the CEO and the ministry than what we're proposing in our legislation, where we have agreements between the board and the ministry.

Mr Cacciavillani: I guess I would bring to your attention that as we read the bill, if the bill is enacted as it's written, it would be very similar to this.

Ms Smith: Given the amendments that you know are going to be brought forward by the minister, would you agree that the BC analogy doesn't really apply?

Mr Cacciavillani: If I could see the amendments in writing, then I would comment on that.

Ms Smith: With respect to compliance directives—you've raised concerns about those—but in any contractual relationship between two parties, there are usually notice provisions for non-compliance, are there not? If you're in a contract with somebody and the other side isn't performing as they should, are there not notice provisions that you can then have a process to let them know: "I don't think you're doing your side of the bargain. Can you straighten up?"

Mr Cacciavillani: That's exactly why we want to be able to have negotiated contracts. So, yes, I would agree, as long as it's negotiated by both sides and not unilaterally imposed.

Ms Smith: Right. So compliance provisions would be acceptable if they were negotiated within the context of the—

Mr Cacciavillani: Yes. Compliance provisions are not in compliance with a negotiated contract, as they're written now. That's what I think I tried to say.

Ms Smith: OK. I think the intention is that they will form a part of the accountability agreements, and therefore be a form of notice provision if there's a disconnect between what's in the accountability agreement and what's actually happening on the ground.

You spoke just briefly about the health quality council, and you were advocating for allowing representatives from health system provider organizations. What we probably are going to be bringing forward in the amendments to this legislation is a provision that would preclude members of stakeholder groups, executives of stakeholder groups, from being on this council, ie, the OHA executive or the OMA executive, but not necessarily a member—such as yourself as chair—of a board of a local hospital. Does that satisfy your concern, or do you think that the stakeholder groups themselves should have representation on this council?

Mr Cacciavillani: I would suggest probably the stakeholder groups themselves. The information that you probably would require at that committee level is more

accessible by the stakeholder groups than myself as chair of the board, or by people like me. That information can be provided to me, but it's just going to filter up from them—so possibly a mix.

1600

The Chair: Mr Klees.

Mr Klees: Mr Cacciavillani, did you notice the parliamentary assistant's silence when you suggested that there should be accountability on the part of the Ministry of Health as well? That should be telling to you and to anyone looking on.

I want to also point out that the whole issue of accountability here seems to focus very much on the CEO. For some reason, this government is drilling right down to the position of CEO.

I don't think the members of the government would disagree now, having had a chance to contemplate this, that there should be accountability on the part of the Ministry of Health as well. If in fact we're going to identify the CEO as someone who should be put on notice, who would the parallel position be in the Ministry of Health, in your opinion?

Mr Cacciavillani: Well, I don't know, but—

Mr Klees: Actually, don't answer that, because you're going to have to work with those people. But my point, I think, is a very valid one, and maybe the parliamentary assistant would like to tell the committee who in the Ministry of Health would be put into the same position of accountability—with the same consequences, by the way, for non-compliance and non-delivery of results—without compensation, unilaterally being able to change the compensation agreements. I'd be very interested. Shall we ask the parliamentary assistant? Why don't we do that? Parliamentary Assistant, who do you think it should be?

Ms Smith: I don't believe I'm required to answer your questions, Mr Klees.

Mr Klees: I think I'm going to ask—

Ms Smith: Are you speaking for the presenter again? You're doing it very well these days.

Mr Klees: I'm asking on behalf of the presenter, actually.

Interjection.

The Chair: There's no point of order here. Mr Klees can use his time as he wishes. The answer doesn't have to be given. It's quite clear: You can sing the national anthem; you can dance for your five minutes. You get to use it.

Mr Klees: Thank you, Chair. I'll save you the agony of singing.

The Chair: The point is, the answer doesn't have to be given.

Mr Klees: I think the parliamentary assistant would rather think about this, and I think she should think about it, and so should the minister and the government.

There's a principle here that you've touched on in your presentation that really goes to the heart of this bill. The parliamentary assistant, in answering one of your questions, also made reference to the whole issue of compliance directives, and yes, she referred to section 22

and the undertaking that the minister is prepared to make with regard to this matter. Yes, he makes reference to the fact that there should be due process provisions, including time frames for notice and so on and so forth. But it's interesting that she didn't finish the paragraph here that the minister sent us.

It goes on to say, "... discussion process, meetings, exchange of documents ... representations that the minister has to consider," and here's the rest of it, "before issuing a compliance directive or an order." In other words, he's prepared to put all of these processes in place; still, he holds on to the right to make a unilateral direction with, by the way, the same consequences. There's no reference to providing in any way relief, and you, or whoever it's directed at, will still be deemed to have agreed.

We've got a problem, and I see the Liberal members of this committee, as these hearings have been going on, becoming more and more dejected. I'm sure that they themselves, quite frankly, cannot believe what they are being asked to support here. I really feel for members of this committee who have to go back to their ridings and face their constituents and who have to deal with the reality that they are being asked to put a piece of legislation forward that is so draconian.

Mr Duguid: We'll deal with it.

Mr Klees: And they will deal with it.

I thank you, sir, for your presentation today.

The Chair: On that empathetic and co-operative note, your time has expired, sir. We do thank you for coming forward. Your input was greatly appreciated.

ESSEX COUNTY MEDICAL SOCIETY

The Chair: Our last delegation of the day, representing the Essex County Medical Society, is Dr David Paterson, the president of that society. Dr Paterson, if you'd like to come forward. You have 30 minutes to make your presentation. You can use that any way you wish. Any time remaining will be split among the three parties. This time the government side will go first.

Dr David Paterson: Mr Chairman and committee members, good afternoon. I'm Dr David Paterson, president of the Essex County Medical Society. Dr Desai, who was to be here, wishes me to express his regret that he was unable to speak to you this afternoon. Following my presentation, I'd be more than happy to respond to any questions that you have.

I have been practising family and emergency medicine in Windsor since 1976. I have been actively involved in the medical community throughout this time and have seen many physicians come to practise here, and, regrettably, seen many leave. I am very familiar with the many issues that confront our health care system, and I hope what I have to say will be of benefit to you in your work on this legislation.

At the heart of this bill is medicare and Ontario's commitment to its principles. As a physician and a Canadian, I am a strong supporter of a health care system

that ensures universal access to quality health services. It is my opinion that if Bill 8 is passed in its current form, the result will be a system that's much worse, not better.

I'm sure you are aware of how concerned physicians across Ontario were when Bill 8 first arrived on the scene. I know that very shortly after Bill 8 was introduced, the Ontario Medical Association addressed many of these concerns with Minister Smitherman directly. My OMA colleagues assure me that ongoing discussions between the minister and other stakeholder groups will no doubt lead to vast improvements to this legislation. The OMA historically has been involved in the government process and was very disappointed that they were not consulted when this bill was conceived. We could have saved you a great deal of time and trouble.

The Canada Health Act was introduced in 1984 and since that time has not been changed—amended or updated. As physicians, we support the principles of this act but have to admit that it is not working the way it was intended. It simply does not reflect the modern demands on our medicare system. This should be a priority for the federal government, to allow provinces to adjust to the new reality of providing medical care in 2004.

The past few days, you've heard from colleagues of mine who have presented you with similar sets of recommendations to those I will offer today. There are several areas of this legislation I would like to address, but my time with the committee is short, so I've decided to focus my remarks on section 16, which deals with block fees; section 9, where the focus is on third party billing; and section 15, which deals with disclosure of information.

Block fees are one-time charges to patients by their physician to cover certain uninsured medical services for a period ranging from three to 12 months. Typically, a patient who opts to pay a block fee would be provided with services such as notes for sick leave from work or school, completion of various forms associated with medical assessments, services over the telephone—for example, test results, advice, prescription refills—transfers of medical records, photocopying, faxing, certificates for health verification, immunization etc. Please remember that these services are very time-consuming and incur a real cost to a physician's practice. They are not covered by OHIP, nor are they billable to the ministry. Block fees are not extra-billing. Patients are given the option of paying for these services separately or opting for the block fee. The physician is required to list each of the fees as well as a description of what the individual charge would be as an alternative to the block fee.

I have found these fees are an effective and easy way to ensure my patients get the kind of care they want. They allow a doctor, for example, to renew a patient's prescription over the telephone as an alternative to seeing the patient in the office and billing OHIP for that visit. This is a cost saver for the ministry and a time saver for both the physician and the patient.

1610

At a time of such an extreme shortage of full-service or comprehensive-care family physicians, the removal of a block fee option is just another nail in our coffin. Full-

service family physicians would be the most adversely affected by this aspect of Bill 8.

As I'm sure you are aware, the Ontario Medical Association publishes a fee schedule of suggested amounts a physician should charge for provided services. Much market research and professional comparisons, including comparisons with the other provinces, are considered when making these guidelines.

At the beginning, OHIP paid a doctor 90% of the OMA fee schedule. In 2004, this is 57.3% of the OMA fee schedule. This may not be such a problem for walk-in clinics, which usually see a high volume of patients and have low overhead costs, but it is an immense problem for the full-service family physician. The type of patient we see is much more difficult, more time-consuming, and usually requires tests, adjusting of multiple medications and consultations with specialists. Taking into consideration the higher overhead required to run a practice like this, the lower numbers of patients seen and our steadily declining income, it's easy to see why traditional family practice is dying out. This is outrageous, because this is the essential type of service the Ontario public—your constituents—requires.

A great many full-service family physicians rely on block fee income to help sustain our service. In my office, block fee income is applied directly to our overhead cost. If it is disallowed, my partners and I must rethink how we'll be able to afford to provide medical service. We are definitely not alone. In my experience, a great many of my patients pay the block fee because they understand the situation we are in and do not want to lose their family doctor. The last thing they want us to be is a walk-in clinic.

Physicians are a self-regulated profession, and I am sure the committee supports the right of doctors and other health care professionals to be regulated by their professional colleges. In our case, the College of Physicians and Surgeons of Ontario, or CPSO, comprised of both physicians and lay members, acts as such a body. The CPSO sets policy and disciplines the profession appropriately. The CPSO is currently responsible for regulating the use of block fees. In my estimation, it has done a good job educating doctors and resolving any concerns about this practice. I should note that the CPSO regulations with respect to block fees are based on a set of guidelines produced by the OMA in close collaboration with the government and the college together.

Another disturbing item is in section 17, which describes the penalties on physicians should they charge block fees. Bill 8 indicates a physician would be subject to a \$25,000 fine and 12-month jail term. Goodbye family practice with Bill 8. Unless the government decides to change the way our profession is regulated, this section must be changed.

Section 9, third party billing: I must say at the outset that two-tier medicine already exists and is not going away, no matter how many rules you introduce. Examples of third party billing include the WSIB, insurance companies etc.

Outlawing third party billing will result in longer waiting lists for investigations, tests and consultations. It will potentially keep workers off their jobs for longer periods of time. Productivity will take a nose-dive. Employees as well as employers will feel the pinch, and the Ontario government will be facing millions of dollars in extra costs.

Insurance companies will not be allowed to get an independent medical expert's advice on claims that require arbitration. This could have far-reaching, dire consequences. Extra fees currently being paid for on-call services by hospitals will be affected by this section.

The provision of other third party services—for example, executive physical programs—generates revenue for existing programs. I got this information this morning. The cardiac wellness program at Windsor Regional Hospital is currently funded by the Ministry of Health, but the amount is not enough to run the program adequately. Third party services are provided before and after times advertised to the public and in no way affect their access to the service. A program such as cardiac wellness relies on this income. If Bill 8 outlawed their ability, services would need to be cut. I could offer many such examples. Outlawing third party services would be a huge error in judgment.

Section 15, disclosure of information: This section should also be deleted from the bill. It requires physicians to report their colleagues to the general manager for contravening the rules of Bill 8. We refer to this as the snitch rule. Please remember this is Canada, not North Korea. Physicians are in full support of mandatory reporting in cases where public safety is of concern. This is the usual test required for mandatory reporting. We are obliged to report, for example, child abuse, sex abuse, cases of unfit drivers and situations where persons may be harmed. The OMA and CPSO have been very successful in applying these rules. There is no issue of public safety here in Bill 8.

Bill 8 gives broad immunity to the crown and permits recoveries to be extracted from physicians directly. The penalties and the authority to do so are sweeping. To add to this insult, chiropractors are not affected because, although they are partially paid by OHIP, they are considered non-designated practitioners.

Physicians are rightly upset about Bill 8. The concepts of universal access and quality health care, two aspects which define medicare, are not addressed in any real way in Bill 8, the commitment to medicare act. There is nothing in this bill that offers real solutions to reduce waiting times for our patients. In fact, in its present form it will dramatically increase waiting times. We need measures that will offer a clear direction to finding ways to decrease waiting time and increase access to diagnosis and treatment.

At a time when we need to be doing whatever we can to recruit and retain our talent, it seems the government is doing their best to drive them away. Bill 8 will cause those looking to Ontario to look elsewhere for a place to practise their valuable skills.

Bill 8 reads like a feel-good statement. However, further analysis reveals that this legislation is a knee-jerk reaction to a problem that requires a lot more thought and effort. It makes health care delivery more complicated, bureaucratic and harmful to our patients.

As a physician on the front lines, whether in my practice or in the emergency room, and also in discussions with my medical college and the ECMS, I see at first hand the crisis that exists in our health care system, and it's getting worse.

When governments make changes to the system, these should benefit patients. Bill 8, in its present form, does no such thing. Perfecting this legislation will be a challenge, but please get it right.

Thank you for this opportunity to speak to you.

The Chair: Thank you, Dr Paterson. You've used up about 12 minutes, leaving us 18 minutes, which would be six minutes per party. We'll start with the government side.

Ms Smith: Thank you, Dr Paterson. First, I'd like to apologize for my phone ringing. I try to turn it off at all times, so I'm sorry that interrupted your presentation.

I appreciate your being here today. As you know, we brought forward this legislation after first reading to get as much input as we can from the public and from stakeholder groups in order to make it the best bill possible, so I appreciate your taking the time to come and discuss your concerns with us today.

I just wanted to address three things in particular. With respect to third party billing, you seem to be concerned that this will somehow impact WSIB issues and insurance companies, but those are considered uninsured services and would not be affected by this legislation. My understanding is that the types of services you're discussing in that section are uninsured at the moment and would not be impacted by this legislation.

1620

Dr Paterson: The way I read the legislation is that third-party services are outlawed, and the way the public would take it, I think, would be the same way I took it, that you are not allowed to get an independent opinion.

If I were an insurance company and I had a claim for somebody with a whiplash injury that begged to be investigated because of investigation of that particular client, I would ask for an orthopaedic consultation or a neurologist or a neurosurgical consultation. By your Bill 8, first of all, that's third party and would be disallowed, the way I read it, and second, even if it were allowed, they could only charge OHIP rates, which are ridiculous. So that physician who is to be consulted for his expert opinion would be paid the same rate, which is already too low; he'd have to take time out of his busy practice to get paid no more to stick his neck out and do an insurance examination. If you made us lose that ability, it would be just a terrible blow to the insurance system.

Ms Smith: But the provision in the act refers specifically to insured services, and what you're describing are uninsured services. What I'd suggest perhaps—I have a

lawyer here from the Ministry of Health who could maybe go through it with you after this.

Dr Paterson: I hope that's the right approach, because that would relieve a lot of problems for me.

Ms Smith: I also wanted to talk to you for a moment about—

Dr Paterson: What about things like the executive physical examinations? A physical examination is an insured service, but an executive insured service is something that has been around for years and years and years. I use that example because it is an insured service that can be expedited at a cost to the company that asked for that service. Personally speaking, I am involved in that here, and it is very welcomed by the people who provide that service.

Ms Smith: Great. I'll suggest that perhaps Laurel can speak to you about that specifically, because I don't think that's addressed in this legislation. If members of the committee want further explanation of that, maybe we can do it offline with the lawyers at another time, if that's OK.

Dr Paterson: I should also mention here that we have in the past expedited things like MRIs and CT scans that are necessary to move a case along. Because the Workers' Compensation Board—an old term—can do this, other employers sometimes use this technique of trying to pay directly for an expedited MRI, and when these are done—and they're commonly done, not just in Windsor but all throughout Ontario. For example, an MRI done at our local hospital would be done before the patients from the general population are seen, so it doesn't put them out, but it is much-needed added income for that hospital. That's common. You be careful, because if you get rid of that, you're creating a huge problem here.

Ms Smith: I appreciate that, and again that would be a third party request, which would make it an uninsured service.

Dr Paterson: No, it's a covered system.

Ms Smith: Dr Paterson, I'll just let you take that up with Laurel, because I think she can explain it better than I.

I just wanted to go over a couple of other things in your presentation before my time ran out, to assure you that we are looking at changes to section 17 in order to amend the language to reduce some of the penalty clauses there that you were concerned about.

Dr Paterson: It was pointed out to me that a fine, a penalty, under some code, is no more than \$5,000. Why would you make it \$25,000 for a doctor? I don't understand that.

Ms Smith: I'm just telling you, sir, that we are going to be amending that to reduce those fines.

I was interested in your views on the section 15 disclosure of information. In that section, what the bill is trying to do is encourage people who work in the health care professions to report queue-jumping so that we can actually police queue-jumping in the system.

Dr Paterson: Why don't we get rid of the queues? We have ideas to answer that question.

Ms Smith: OK. I wanted to ask you a couple of questions about block fees. Am I out of time?

The Chair: You have had a couple of questions. You could probably ask a brief one.

Ms Smith: Great. I'm interested in your views as a family doctor on how we could manage block fees better. There's some concern being raised about excessive block fees being charged, or block fees being charged by physicians as a type of key money to ensure that they have a family doctor. I was wondering—

Dr Paterson: That's not correct.

Ms Smith: We have heard some examples of that. I was just wondering if you could foresee a type of system that would allow for payment of a fee that would then be credited against future services.

Dr Paterson: That's what a block fee is right now. There are regulations that cover it, and suggested amounts, although I have to admit that does vary from practice to practice. We would welcome a guideline to that, but we certainly would not welcome getting rid of the block fee.

Mr Klees: I just want to say that with regard to this discussion that has taken place, I think it's important that all members of the committee fully understand what Dr Paterson is saying and that we are all fully apprised of the dialogue that goes on there.

Ms Smith: If Mr Klees would like, we could have the person from the ministry speak to that issue right now.

Mr Klees: I'll take my time, and I'm happy to have her speak to that after I have my session with Dr Paterson.

Ms Smith: All right.

Mr Klees: Dr Paterson, your concern about block fees is an important one, and we hear you and we've heard representations throughout the committee hearings on this issue. But it's interesting as well that in the document we've received from the minister there is no reference at all to that section. In other words, there is no indication that the minister is prepared to change his position on that, and so I'm suggesting to you that you need to be vigilant here on this issue.

I am hearing the parliamentary assistant say that there seems to be widespread abuse of block fees being used as an access by physicians across this province to just have—

Ms Smith: On a point of order, Mr Chair: I don't believe I said it was widespread. I suggested that there has been some evidence.

The Chair: It's probably not a point of order, but the point is taken. Mr Klees, continue.

Mr Klees: Thank you. I think it's extremely important that this committee fully understand, and the government understands, that this is not an initiative that is dreamed up by doctors, that it is in fact overseen by the College of Physicians and Surgeons of Ontario, that there are guidelines. I would think that a reasonable amendment to this bill would be to place block fees under the authority

of the college and ensure that in fact there are guidelines that are enforceable through the college to ensure that the realities of your practice are, on the one hand, understood, and that patients are protected.

Dr Paterson: I agree 100%.

Mr Klees: With regard to the issue of the kind of penalties that you refer to, the minister did come back in his document here and he is saying that he's prepared to consider reducing the maximums of \$25,000 and \$50,000 down to, say, \$10,000 and \$25,000. So there you go. You can feel some comfort in that, right?

Dr Paterson: I feel no comfort in that whatsoever.

Mr Klees: What does it say, even though the Liberal government here is saying, "This is a unique situation. We're just putting this bill out, it's only first reading, and we really want to have some advice from stakeholders"?

Dr Paterson: We're trying to give you that advice. Take that part of the bill out.

Mr Klees: What does it further say when this first-reading bill comes out with such draconian measures that clearly target your profession, health care workers and boards of governors across this province? What does it say about the coming-out attitude of this government toward the entire health care sector?

Dr Paterson: I hope it says that they didn't really understand what they had in that bill.

Mr Klees: And if they did understand it, what does it say?

Dr Paterson: It says terrible things.

Mr Klees: Thank you, sir.

The Chair: Ms Martel.

Ms Martel: Thank you for being here today. I wanted to ask a question with respect to block fees. At the bottom of page 5 you say, "As I'm sure you are aware, the Ontario Medical Association publishes a fee schedule as a suggested amount a physician should charge for a provided service." That comes in the section just under block fees. "Provided service," I'm assuming, refers to an uninsured service.

Dr Paterson: The reason I included that is because the fees we are paid have been falling more and more short of what we need, that it's very expensive to operate a full family practice, and because our fees are so far behind what they were before that we really have no choice but to ask for a block fee to help pay for our overhead.

1630

Ms Martel: Can you get a list of what can be charged under a block fee?

Dr Paterson: Yes, I certainly can.

Ms Martel: As a member of the public, where would one get that list, if a member of the public wanted to know?

Dr Paterson: We produce that in our own office. I have to make the point that there are, to my knowledge, no specific guidelines on what a block fee should be, how much it should be. So yes, I guess there would be room for abuse in that, but don't take them away. We would

welcome a guideline as to what reasonable block fees would be.

The other thing I should mention here is that some doctors' offices do much more comprehensive, in-depth medical care than other offices, and the costs that they incur by running such a practice are much higher. So there should be room for an adjustment of block fees depending on the quality and the value of services you offer. Treating a cold and cough does not come close to treating somebody with angina, GI bleeding, depression etc.

Ms Martel: I'm just referring back to a presentation we had earlier today that talked about block fees. It said:

"Getting information on what charges are allowed at what levels and whether a physician can force patients to pay block fees is very difficult. We have been unable to get a list of services for which physicians can charge from the college. We can get the list from the Ontario Medical Association if we pay a fee of more than \$100."

Do you know if that's correct?

Dr Paterson: I don't know if that's correct. I can give you a list of our personal block fee letter, which is open to all our patients.

Ms Martel: That would be from your practice.

Dr Paterson: From our practice, but it's pretty representative of what happens down here.

Ms Martel: But does the college now provide some guidance on this?

Dr Paterson: They provide guidelines: what is covered by a block fee, what it entails and that you have the choice of paying for each service independently.

Ms Martel: If the service is provided or isn't.

Dr Paterson: Yes.

Ms Martel: Does the college not make that available to the public?

Dr Paterson: Yes, the college has guidelines, and they have come out with the Ontario Medical Association, as well as working with the government, in making those guidelines. I don't know what the amounts are.

Ms Martel: My question, though, was: Is that something that is available to the public? This is the third presentation we have had that suggests that the college would not make that available and that there was a fee to get that from the medical association. I just wanted to know, if that is true, why that would be the case?

Dr Paterson: I don't think it's true, and I would be very happy to contact the OMA and the college on your behalf and provide you with that information.

Ms Martel: That would be great. Thank you.

The Chair: Thank you, Dr Paterson. We do appreciate you coming forward.

Seeing as it is the end of the day and it would not impose on any other member of the public's presentation time or anything, I wonder if the legal representative from the Ministry of Health would like to come forward and perhaps give a comprehensive and brief answer to the questions that were raised by Dr Paterson on what is actually an insured service.

Could you introduce yourself for Hansard, please.

Ms Laurel Montrose: My name is Laurel Montrose. I'm senior counsel with the Ministry of Health, and I specialize in the OHIP area. I worked on this bill, so I can give you some of the legal background. I can be comprehensive, but I can't necessarily be brief; I can be brief, but I can't be comprehensive.

Mr Klees: Can I just confirm that this in fact is being caught on Hansard?

The Chair: Yes.

Ms Montrose: This bill, with the exception of the provision on block fees—which, as you know, Doctor, deals with charges for uninsured services; the other provisions deal with charges for insured services. WSIB services are not insured services so they're not affected by this bill. Other uninsured services, include things that are commonly known as third party services, but that's a colloquial term; it doesn't have any legal meaning. Generally speaking, an executive physical is an uninsured service. As I said from the beginning, with the exception of block fees, the bill doesn't address WSIB and doesn't address uninsured services. So there's nothing in here that would preclude those services continuing to be provided and financed in the same manner in which they are currently provided and financed.

Mr Klees: Could I just ask, then: There are numerous services that are uninsured that are now incorporated into block fees?

Ms Montrose: What's in a block fee depends upon the person who's charging it. A block fee can be a contract for one uninsured service over a period of time, or it can be a contract for any number of uninsured services over a period of time. What the health care provider chooses to include is up to him or her.

Mr Klees: Right, so in that case, depending on the physician, there may be a list of 20 or 10 services that he or she is now getting paid for that, on passage of this bill as it is, they can no longer charge for?

Ms Montrose: With respect, I don't think that's a correct interpretation of the bill. It's not an issue of whether or not a physician or provider can charge for an uninsured service. There's no prohibition against charging for an uninsured service. The question is whether or not the charge is on a per-service basis or, if you'll excuse the expression, on a bulk-buy basis.

The bill simply says that if you're selling uninsured services on a bulk basis —and I'm sorry for the colloquial term, but it's the best metaphor to use—you will have to comply with regulations that are enacted under the legislation. So this bill does not purport either to prohibit block fees or to regulate the amount of block fees; it only deals with circumstances in which block fees can be charged. Again, it doesn't deal in any way with individual charges for uninsured services.

Mr Klees: Well, I'm more confused than I ever was.

Dr Paterson: I'm worried about being fined \$25,000 or \$15,000 for charging block fees that we need, and we're not sure what they really cover.

The Chair: It was my hope that in a short period of time we were going to be able to clarify this verbally, and that doesn't appear to be happening.

Ms Montrose: It's a complicated issue, but there's nothing in here that prohibits charges for uninsured services.

The Chair: Would it be fair to say, though, that in the next period of time, we would be able to provide a member of the public who asked with an explanation of what you're trying to describe verbally—not by the end of the day, but at some period in the future?

Ms Montrose: I think we could come up with some brief summary of what the provision says, yes.

Mr Klees: Not only for a member of the public, but for members of the committee?

The Chair: Absolutely, and that's why I asked, because I think that would be of benefit to all three parties represented here. And obviously, to the doctor. Thank you.

Just a little bit of housekeeping: For those of you who are going home tonight, the van leaves at 5:15. Could we have a very brief subcommittee meeting before that time to try to sort out some other particulars.

We're now adjourned to Toronto.

The committee adjourned at 1639.



STANDING COMMITTEE ON JUSTICE AND SOCIAL POLICY

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Ms Laurel Montrose, legal counsel, Ministry of Health and Long-term Care

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Première session, 38^e législature

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Monday 23 February 2004

Journal des débats (Hansard)

Lundi 23 février 2004

Standing committee on justice and social policy

Commitment to the Future
of Medicare Act, 2003

Comité permanent de la justice et des affaires sociales

Loi de 2003 sur l'engagement
d'assurer l'avenir
de l'assurance-santé

Chair: Kevin Daniel Flynn
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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON
JUSTICE AND SOCIAL POLICY

Monday 23 February 2004

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

COMITÉ PERMANENT DE LA JUSTICE
ET DES AFFAIRES SOCIALES

Lundi 23 février 2004

*The committee met at 1000 in room 151.*COMMITMENT TO THE FUTURE
OF MEDICARE ACT, 2003LOI DE 2003 SUR L'ENGAGEMENT
D'ASSURER L'AVENIR
DE L'ASSURANCE-SANTÉ

Consideration of Bill 8, An Act to establish the Ontario Health Quality Council, to enact new legislation concerning health service accessibility and repeal the Health Care Accessibility Act, to provide for accountability in the health service sector, and to amend the Health Insurance Act / Projet de loi 8, Loi créant le Conseil ontarien de la qualité des services de santé, édictant une nouvelle loi relative à l'accessibilité aux services de santé et abrogeant la Loi sur l'accessibilité aux services de santé, prévoyant l'imputabilité du secteur des services de santé et modifiant la Loi sur l'assurance-santé.

ONTARIO HOSPITAL ASSOCIATION

The Chair (Mr Kevin Daniel Flynn): Our first delegation this morning is from the Ontario Hospital Association. Joining us, as I understand, are Hilary Short, Tony Dagnone and Ruthe-Anne Conyngham. The rules are that you have 20 minutes. You can use that time any way you see fit. If there is any time remaining from your presentation within that 20 minutes, we'll either split that among the three parties or, if there are only two or three minutes left, we'll allow the one party to ask you a question. Other than that, the time is yours, and I've got 10:01. The floor is yours.

Mr Tony Dagnone: Good morning, Mr Chairman and committee members. It's our pleasure to be here to provide you with some very significant information and advice around Bill 8. My name is Tony Dagnone. I am here in my capacity as chair of the Ontario Hospital Association. That association represents 159 hospitals throughout our very proud province of Ontario. That membership employs over 200,000 valued health care professionals working in partnership with over 50,000 volunteers. That's a lot of people who have made a commitment to our hospitals.

Representing the 4,000 hospital trustees this morning is Ruthe-Anne Conyngham. She is the board chair of St

Joe's health care in London and also a member of the OHA board. With me, as you indicated earlier, Mr Chairman, is Hilary Short, the president and CEO of the Ontario Hospital Association.

I begin by just making a general comment that hospitals are very vital community resources that touch the lives of millions of Ontarians. This year alone some five million citizens will call upon one of our hospitals for some type of care.

As MPPs in this province, you are aware that the hospitals in your home communities and across your large ridings are governed by dedicated voluntary boards. The members of these boards are community leaders, business people and others with a civic orientation to community service. Many of you will know them as your neighbours and friends. These people are entrusted with the oversight, fiscal stewardship, mission and strategic direction of their hospital with a single purpose in mind, and that is to create healthier communities. In part, these community leaders are a big part of the reason why today Ontario hospitals are viewed as leaders in both accountability and value for taxpayers' money.

Our hospitals have some of the most extensive patient satisfaction surveys and hospital performance reporting in North America. We take those particular results very seriously each year.

We are here today to tell you that we unequivocally support the government's goal in introducing the Commitment to the Future of Medicare Act. We do enjoy strong collaboration with our minister, with ministry officials and his advisers. Significant progress has been made, and we have narrowed the range of issues down to just a few.

We support and embrace key provisions of the bill, including the establishment of a new health quality council; embracing the five key principles under the Canada Health Act; adding that very important principle of accountability; and entering into accountability agreements for our hospitals. But unfortunately key parts of the bill, as originally drafted, run contrary to these principles because they fundamentally take away the very essence of local hospital boards and weaken accountability goals.

Several sections, as written today, permit the government to ignore hospital boards and make unilateral decisions directly affecting the management, the priorities

and ultimately the patient care delivered in each and every hospital in Ontario.

It is a given here that there is more to do in making our hospitals even more accountable than they are today. That is why we have been working collaboratively with the Ministry of Health and Long-Term Care on the development of new funding formulae for hospitals, as well as the development of workable performance agreements.

It is the OHA membership, led by voluntary community boards, that agreed to developing such agreements to guide the delivery of care in your respective communities across Ontario. For that reason, we believe strongly that all sections of Bill 8 must support community governance before the OHA membership can endorse the final bill. With that, I would ask Ruthe-Anne to continue.

Mrs Ruthe-Anne Conyngham: Good morning. Roy Romanow reported, "People are no longer prepared to simply sit on the sidelines and entrust the health care system to governments and providers. They want to be involved, engaged and acknowledged, and well informed as owners, funders and essential participants in the health care system."

It is through our volunteer boards that communities across Ontario have the ability to influence how local needs are met. We are the eyes, ears and hearts of our communities, positioned squarely at the centre of our cherished health care system.

As a board chair, I believe strongly in accountability. If a hospital does not live up to the necessary standard of accountability, then the minister already has powers under the Public Hospitals Act to take action. We are prepared to work even further on improving these measures and identifying other remedial approaches.

The central problem with Bill 8 is that it gives Queen's Park the power to impose absolutely anything it likes on an individual hospital. The government can ignore the expertise of the people who know the most about the hospital and the services it provides to the community.

I urge you not to underestimate what is at stake here. In this time of severe funding shortages, local volunteerism is the cornerstone of efforts that raise hundreds of millions of dollars each year to help sustain our hospital system. I am not talking about a system that allows people to be involved who are merely interested in being associated with their community hospital. Those days are gone forever. I am talking about a system that taps into the best and brightest talent in our communities right across this province. I am talking about a commitment that creates passion and allows Ontario hospitals to meet the standard of excellence already being achieved. I am talking about a commitment on the part of volunteer trustees that has been shaken to its foundation because of this bill. Hilary?

Ms Hilary Short: Since the introduction of Bill 8, I want to let you know that the OHA has been working very closely with Minister Smitherman and all his senior staff from the ministry as well as our hospital members on proposals for amendments.

We have made some significant strides, as you have heard, in refining the bill as outlined in the minister's February 19 draft framework for potential changes, but I am here to say that several fundamental issues still need to be resolved.

First of all, in section 20, we strongly recommend that the accountability provisions of Bill 8 be amended to ensure that the public interest is one of those being considered that will ensure greater government accountability. As the bill now stands, the government would be less accountable, in our view, for ensuring timely access to quality care in communities across Ontario.

Second, while we do support enhanced accountability as indicated in section 21, it is imperative that the government not impose the accountability agreements. They really need to be negotiated with the hospital boards. The ministry has agreed these agreements should be negotiated with the boards, but we think it is important that they not be imposed; that they be in fact negotiated.

Third, to keep from undermining the role of local hospital boards, as Ruthe-Anne has indicated, we believe strongly that sections 26 and 27 should be deleted in their present form. In that present form, it puts the CEO really and truly in conflict with the board. As you'll see in our more detailed presentation, the BC Auditor General clearly rejected this approach when it was introduced in British Columbia.

In conclusion, we want to assure you that we do support this bill. Ontario's hospitals support medicare. We support local voluntary governance. We very strongly support greater accountability. Bill 8 has the potential to be a powerful symbol of our province's commitment to public health care. That is why we will continue to work with you, the committee, the minister and his team to achieve the improvements we believe are absolutely critical to make it a success.

Thank you for the opportunity to present, and we're all ready to take any questions.

The Chair: That's wonderful. Thank you very much. You used up about nine minutes, so I'm going to propose we split the rest of the time, starting with the official opposition.

Mrs Elizabeth Witmer (Kitchener-Waterloo): Thank you very much, Mr Chair. Good morning. That was a great presentation. I know you have been working with ministry staff in order to ensure that this bill obviously does, at the end of the day, demonstrate the sincere commitment of this government to the future of medicare and also ensures there will be accountability but that that accountability goes both ways, that the government is also accountable to the people. I know there are some key changes that you're looking for. I know you have some very serious concerns, and I know the minister has already acknowledged that the tone of this bill was not right. There are going to have to be some very, very substantive amendments made in order to ensure that the accountability goes both ways and that obviously local boards continue to play a critical role in their hospitals.

My question to you is, what are the key amendments—and I know you've made reference to them here—could you expand upon the key amendments that you as the Ontario Hospital Association need to see before you can wholeheartedly support this bill as an instrument that is going to demonstrate the commitment to the future of medicare?

1010

Ms Short: I will focus on three issues. Number one, we are working very constructively in a collaborative way with our hospitals and the government to work on performance agreements. We think the performance agreements that we enter into need to be negotiated. This is a whole new approach to hospital funding, management and governance. We believe very strongly that those agreements need to be negotiated between the ministry and the hospital boards in a collaborative fashion.

Number two, we really believe that this issue of public interest needs to be up front and centre. Under the Public Hospitals Act at the present time, if you as a government have concerns about the care and management of a hospital, what is happening in a hospital, the provisions of the supervisor kick in. The government has the authority to send in a supervisor, an investigator or an inspector. That is a good power and it has been used, but that requires approval of cabinet. It can't be done arbitrarily. We're not suggesting this minister would do anything arbitrary, but we feel there needs to be protection so that under the Public Hospitals Act it's clear when you can use that power. Under Bill 8, as it's currently written, that is not required.

We've talked to the ministry about the fact that they see this as being used only in very exceptional circumstances, but we have not yet been able to define exactly what those exceptional circumstances are, so we believe that needs to be really carefully looked at.

Furthermore, if the government is able to reach in and deal with a CEO problem in exceptional circumstances, that really puts the CEO in a very blurred line of accountability, so that is the third piece that needs to be changed.

So, negotiated agreements, a public interest provision and our preference would be to see 26 and 27 removed entirely.

The Chair: Mrs Witmer, your time has expired, unfortunately. We'll go to Ms Martel.

Ms Shelley Martel (Nickel Belt): Thank you for being here this morning. Can I ask when you first saw a copy of this bill?

Ms Short: We saw it the day it was introduced.

Ms Martel: I think it would have made much more sense for the government to actually have consulted with you before they came forward with this because, to be quite blunt about it, the government hasn't been getting much of a good ride on this bill to date. Frankly, it's no wonder to me, because if you look in the accountability agreement section, for example, it says things like, "The minister may at any time issue a directive compelling a health resource provider or any other prescribed person,

agency or entity to take or to refrain from taking any action that is specified in the directive or to comply with one or more of the prescribed compliance measures." There are at least four other provisions between sections 19 and 32 that are the same.

On Thursday we got a copy of some of the proposed changes that the minister intends to make. I regret to say the government still isn't getting it right, despite all the negotiations that seem to have gone on. You talked about the word "preamble" needing to be in "Matters to be considered," section 20. I agree with you. Unfortunately, in the draft he gave us on Thursday the minister said the reference to public interest is only going to appear in the preamble. It says nothing about it being in section 20.

Two other points: It says very clearly in section 22 that the minister still has the sole ability to issue a compliance directive or an order. The word "negotiation" does not appear. Third, it's still very clear that the ministry can claw back compensation from a CEO, which would be totally contrary to the role of the board.

I regret to say that despite the consultations you say have gone on, what we saw on Thursday doesn't give me any sense whatsoever that the government has actually listened. In fact, the government still has the power, the minister himself, to issue a compliance directive or an order—it doesn't sound much like negotiation to me—and still is assuming the role of being an arbitrator in terms of compensation clawback from CEOs, which is clearly the role of the board.

What do you have to say about this, which we saw Thursday?

The Chair: You have about a minute to say it.

Mr Dagnone: Points well made. I think what we have to underscore here is that we have made very good progress. On those items that you have identified, more progress is wanted. That's what our members are all about. We want to do the right thing. There's too much at stake here. We need to embrace what the volunteer governance system is all about here because in other provinces, where there's an absence of volunteer governance, I can tell you that they've got even more challenges than Ontario does.

I guess the bottom line is that we will continue to work with the minister, his advisers, to make sure that we have the right solution here that will answer the public interest.

Ms Kathleen O. Wynne (Don Valley West): Thank you very much for your presentation and for the tone of the presentation. Although the final amendments aren't out, because we're not at that stage yet, I know you've been working very hard and we really appreciate that.

One of the things about bringing out a bill for hearings after first reading is that there are a lot of changes that are going to be made to it, and that was the point.

Having said that, I just wanted to check two things. The public interest issue: You've raised an issue of where you want it specifically in the bill. If it were to be in the preamble that public interest were to underpin everything that is done, would that work for you? Can you talk about

why that would be a problem, or whether it would be enough for you?

Ms Short: It would certainly help a lot, and the minister has indicated that that would be in the preamble. I guess we're just used to seeing—in the Public Hospitals Act, that's how it really is shaped. We just want to be really sure that there is no opportunity for any kind of arbitrary action by any government.

Ms Wynne: Yes.

Ms Short: That's the issue.

Ms Wynne: Fair enough. I think what we're trying to do is infuse the whole bill with that need for action in the public interest.

The second issue is on the negotiated and renegotiated accountability agreements, because it won't just happen once. I understand you're looking for the term "negotiation." Can you talk about what that framework of negotiation or discussion would look like? If we were to move toward giving the boards the sorts of standards and information about what the issues were going to be ahead of time, and there were some time for them to prepare to respond and then there were a discussion, is that the kind of thing you're looking for, or what exactly is it that you need?

Ms Short: I just say to you that before Bill 8 was introduced, we'd already made that commitment to work with the ministry on working on performance agreements. We have an extensive committee structure, if you like, of literally hundreds of people working jointly with hospitals, with the ministry, on trying to work out this new approach to how we could get to performance agreements. That work is continuing, and I would say we don't quite know yet what the shape of those agreements will be. This is all very new to Ontario.

I would like to stress, as we have talked with the ministry, that we leave that work to the processes already in place and that we'll learn from that collaborative work. So we don't know exactly what the agreements will look like. The point is, we think they should be negotiated, there should be a say, there should be a discussion between the local community and a clear understanding between the hospital and the government rather than their being imposed.

Ms Wynne: Right. I understand that. Did you want to add to that? No. We're done.

The Chair: You've got about 20 seconds. Can you do it in 20 seconds, Mr Dagnone?

Mr Dagnone: I'm just trying to further respond. We believe that the best agreements can be arrived at if there's a meeting of the minds in terms of exactly what it is that we're trying to achieve on behalf of our communities, have our trustees represented there, have the Ministry of Health represented there, and then have the people who will be charged with making these agreements happen. They ought to be part and parcel of that at the front end. If you've got that joint concurrence at the beginning, the chances of that succeeding are so much higher.

Ms Wynne: We need buy-in from them.

Mr Dagnone: Ownership.

The Chair: I'd like to thank you for appearing before us today. We certainly did appreciate your presentation.

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ONTARIO DENTAL ASSOCIATION

The Chair: I now call forward the Ontario Dental Association: Dr Blake Clemes, Frank Bevilacqua and Linda Samek. I'd like to thank you for attending today—same rules as before. If you could identify yourselves for Hansard when you start, that would be appreciated. You've got 20 minutes. You can use those 20 minutes any way you like. At the end of the presentation, if there is any time, it will be split among the three parties, unless there's a very short period of time. In that case, it'll be only one party.

Dr Blake Clemes: Good morning. Thank you for this opportunity to address the standing committee on justice and social policy regarding Bill 8, the Commitment to the Future of Medicare Act. I'm Dr Blake Clemes, president of the Ontario Dental Association. With me today are the ODA director of government relations, Frank Bevilacqua, and Linda Samek, the director of professional affairs.

The Ontario Dental Association, ODA, is a voluntary professional organization which represents over 6,000 dentists, more than 80% of the dentists of Ontario. The ODA supports its members, is dedicated to the provision of exemplary oral health care, and promotes the attainment of optimal health for the people of Ontario.

As a professional organization representing independent health practitioners, the ODA is committed to the delivery of quality care within an accountability framework outlined under the Regulated Health Professions Act, the Dentistry Act and related profession-specific regulations. The ODA believes in and promotes the delivery of patient-centred care based on the individual needs of the patients.

As we begin our remarks to the committee today, it is important to note that the ODA recognizes that Minister Smitherman has indicated that a series of amendments will be made to the bill in an effort "to get it right." Without the opportunity to consider all of these amendments fully, it's difficult for the ODA to understand if the proposals will improve upon the existing bill. We look forward to having more time to examine the amendments and providing a more detailed written submission to the committee.

I would be remiss if I didn't make a brief comment about the approach taken by the minister and the process for Bill 8. It is healthy to acknowledge that a piece of legislation may be flawed. Allowing an opportunity to make substantive revisions to a legislative proposal before it is accepted in principle serves the best interests of Ontarians. A process that allows ample opportunity to develop the best possible legislation is a goal for which we should all strive. The ODA thanks the minister for expressing his personal interest in addressing some of the concerns raised by the health sector.

Subsection 9(1) prohibits a physician or designated practitioner from charging more or accepting "payment for more than the amount payable under the plan for rendering an insured service to an insured person." The ODA stresses that some procedures provided by dentists are deemed to be insured services in certain instances, yet these same procedures provided to an insured person are not deemed to be covered services in other settings. Dentists seek confirmation that nothing in this proposal will interfere with the current practice of dentists to charge for these same procedures, irrespective of where they are performed, when the OHIP coverage criteria are not met.

The application of subsection 9(2) creates great concern for the ODA and individual dentists. It is unnecessary and inappropriate to force the dental practitioner or other designated practitioners to deal directly with the plan rather than with the patient. Even though many practitioners may choose to deal with the plan, this is an intrusive provision that should be removed.

Section 10 continues to allow the Ministry of Health and Long-Term Care to enter into an agreement with the Ontario Dental Association to negotiate about insured dental services and the amount payable to dentists under the plan. The ODA values the importance of such a mechanism.

It is the view of the ODA that the existing Health Care Accessibility Act did not achieve appropriate balance. To introduce greater fairness in the negotiating process, the ODA recommends that the ministry be obligated to negotiate with the named associations on a timely basis.

The need for timeliness reflects ODA's first-hand experience of having no change to the OHIP schedule of benefits for the services of dentists between 1987 and 2003. This is not because of real or perceived costs for dental services rendered under the plan. Quite simply, there was no commitment from the ministry to get to the table until just a few years ago. This is not an acceptable process, and that is why dentists seek these important changes to the bill.

On a related matter, subsection 10(3) permits the Lieutenant Governor in Council to "make a regulation providing that the minister may enter into an agreement ... with a specified person or organization other than an association mentioned in subsection (2)." The ODA recognizes that this section reflects the current provisions outlined in the Health Care Accessibility Act; however, the ODA continues to oppose the specific wording of this section. The ODA recommends that subsection 10(3) be revised to read, "The Lieutenant Governor in Council may make a regulation providing that the minister may enter into an agreement under subsection (1) with a specified person or organization other than an association mentioned in subsection (2), provided that there is consultation with and the agreement of the profession-specific association named under subsection (2) regarding the person or organization to be named under this subsection."

This proposal ensures fair and appropriate representation for the specific profession or a subcategory of the

profession and protects against having a single individual arbitrarily named to enter into such negotiations who may not have either the consent of the association or represent the interests of the profession or the patients served under the plan.

Section 14 introduces broad disclosure provisions related not only to insured services, but also uninsured services provided to an insured person. Dentists are independent, self-regulated health professionals who provide a wide range of oral health services, and these services are primarily not insured by OHIP. The complexity of the care, the co-morbid medical status of the patient and/or the need for intubation and anaesthesia require some oral health procedures to be delivered within the publicly funded hospitals. However, many of these dental procedures are not covered by OHIP. The ODA believes that any services not covered by OHIP should not be reported to the general manager.

The ODA recognizes that related regulations may provide more clarity and detail regarding the application of this section. Nonetheless, this approach appears to abrogate the spirit of the new provincial privacy protections being considered in Bill 8. The reporting provisions under section 14 are excessive and take primacy over confidentiality, other regulations or acts and appear to apply directly to reporting about uninsured services. The ODA does not support the introduction of such sweeping powers and requirements. Given that the minister has indicated that Bill 8 provisions will not supersede the protections contained in Bill 31, this section should be clarified in Bill 8.

Section 15 sets out conflict-of-interest rules and requires prescribed persons to report their beliefs that a breach of the conflict requirements has occurred. Dentists, physicians and optometrists, the professions named in the legislation, are self-regulating professions, and this requirement to report a matter to the general manager interferes with the accountability process of self-regulating professions and the professional colleges charged with regulating the profession. Moreover, this section and others within the bill must be clarified to ensure that dentists, who provide a very limited number of OHIP-insured services under very restrictive circumstances, are not seen to be permitting patients to queue-jump when they charge for the same non-OHIP-insured services, regardless of setting. To place this into perspective, the vast majority of patients are cared for within the private practice setting; however, some patients need to have some oral health care provided within the hospital setting. A limited number of the procedures provided in hospital are OHIP-insured. It is important to ensure that the dentist who provides these same services in the private office setting is not deemed to be charging a fee to queue-jump.

Section 17 sets out penalty provisions. The ODA is pleased to learn that the minister will be addressing the excessive penalties set out in the bill. The ODA asks that the penalties be reduced, both for the individual and the corporation. According to existing provisions, regulated

health care professionals cannot incorporate with anyone other than a member of his or her own profession. Therefore, the corporation often is an individual practitioner, and the extraordinary penalty of \$200,000 does not appear to consider this fact. The ODA recommends that the penalty provision for an individual and a health profession corporation be the same. Further, the ODA believes that the proposed penalties are excessive and must be reduced.

The ODA does not support the proposed provisions for retroactivity set out in section 18. How are individuals expected to comply with regulations that are not yet in draft form? This provision should be removed.

Despite the reference to accountability agreements in this part of the bill, the reality is that there are no provisions for agreements to be reached. Instead, the powers to compel a health resource provider, prescribed person, agency or entity to enter into an accountability agreement are invested entirely with the minister. Further, the ODA supports the minister's suggestion that the explicit reference to the minister's capacity to unilaterally vary or terminate an accountability agreement be removed from section 24. This change is required to ensure this legislative proposal envisions the introduction of an open and fair accountability process.

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The minister has indicated that section 19 will be amended to make it clear that individual dentists, or group practices, along with organizations like the ODA, are not subject to part III of Bill 8. The ODA supports such an amendment to Bill 8.

Section 28 underscores the problems with part III of the bill. Despite any agreement, the unilateral changes of the minister to the agreement are to be deemed to have been mutually agreed upon and, despite any provisions to the contrary, the recipient or party to the contract or agreement would not be entitled to any sort of payment or compensation. The philosophy of entering into agreements in good faith should serve as the foundation of any agreement with the minister. This proposal provides the minister with excessive, unrealistic and unreasonable powers.

Subsection 29(3) provides for public disclosure of personal information. If "personal information" includes personal health information that identifies and is linked to an individual, it's disturbing that the minister would be permitted to disclose such information publicly without the consent of the individual. Bill 31 must also take precedence in this regard.

The section 30 exemption from liability for the crown, the minister or others acting under this part further erodes the fundamental expectations of dealing with the ministry in good faith.

There are extensive regulation-making powers under section 32. These powers undermine the professional working relationship between the ministry and the health care community. The proposals threaten the process of arriving at agreements to provide publicly funded services. Bill 8 sends a strong message to all health care providers that the ministry does not trust or respect the

remarkable commitment that is made to Ontarians by health care providers on a daily basis. The ODA encourages the minister to move ahead with changes that would legislate a mandatory 60-day consultation period on all regulations.

Section 15 raises concerns for dentists who work routinely with their medical colleagues in the delivery of care within a hospital setting. For instance, anaesthetic services are insured services in some instances when performed by a physician as an adjunct to a dental procedure performed in a hospital, but at other times, the anaesthetic procedure is not deemed to be insured. The ODA seeks to clarify that a physician providing the anaesthetic services would be able to obtain payment from a patient where the procedure is not deemed to be an OHIP benefit.

The ODA has similar concerns in subsection (3) of section 15. There are several instances where insured and non-insured services are provided to the same person during a single visit. It frequently is necessary for dentists to provide non-insured services within the hospital setting even though the adjunct anaesthetic procedure is insured under the plan. The ODA seeks clarity that this section will not interfere with the existing billing practices related to such circumstances.

The amendments to the Health Insurance Act under section 40 include permitting the minister to "make an order amending a schedule of fees referred to in subsection (2) in any manner the minister considers appropriate." Once again, the ODA questions why the minister would put a wedge between the ministry and health care providers. Bill 8 goes a long way toward demoralizing the health care sector and does nothing to foster a willingness to work with the government. For years, the dental community has substantially subsidized the delivery of publicly funded oral health services. Dentists have continued to provide medically necessary OHIP-insured services in-hospital despite having no increase in the OHIP schedule for almost two decades following 1987. Just as this profession considered that it was turning a corner and improving on the working relationship with and understanding of government with respect to these important payment issues, this bill was introduced. An amendment to address this major concern should be introduced.

In its original format, Bill 8 raises significant concern about the interest of the ministry to work with health care providers in good faith. The ODA believes that health care providers should receive fair compensation for the delivery of care without the fear of coverage rollbacks, clawbacks or elimination. The principle of fairness is missing completely from the tone and language of the bill. We trust that the amendments will address this and the other concerns raised by the ODA.

Thank you for this opportunity to address the committee, and we would entertain any questions that you might have.

The Chair: Thank you, Dr Clemes. You've left us with about six minutes. That's time for a brief question from each party, starting with Ms Martel.

Ms Martel: Thank you for being here this morning. I think the presentation was quite clear. The question I had, however, was on page 2, top of the page: "The application of section 9 creates great concern for the ODA and individual dentists." Could you just outline to me your specific concern there so I understand the example?

Dr Clemes: Do you want a specific example?

Ms Martel: That would be great.

Ms Linda Samek: I guess the issue is that there are a very small number of services that are considered to be insured. What happens here is that those same services provided in another setting are not deemed to be insured and it's the setting sometimes that makes this, because they have to be in the hospital setting to be insured. However, sometimes, even in the hospital setting, they may not be insured because they don't meet all of the criteria for coverage. It's really that difficulty that dentists have in trying to understand how this bill is going to capture those services. There are a number of services that are routinely done in the office, but because of the complexity of the presenting patient, they would have to go to the hospital setting for other times. It's just making sure that we're not caught up in—seeing those as somehow caught under this bill.

Ms Wynne: Thank you for your presentation and the explicit suggestions. I just wanted to follow up on that question because certainly it's not the intention of this legislation to undermine what's going on and what's working. I guess I have a general question: Do you agree with the concept that we need to put an accountability framework in place?

Dr Clemes: Certainly.

Ms Wynne: So you concur with that. OK. The way the bill is written, it's dealing with insured services—subsection 9(1)—right? So what would the language look like that would give you comfort there? Because, as I hear your explanation, nothing that's written here would change what you're billing for. So instead of saying all the things that we're not dealing with, we're talking about what we are dealing with, which is insured services, which includes where they're performed, right? So what's the language that you'd be looking for?

Mr Frank Bevilacqua: I think one of the major concerns we have around that is, as was outlined by Dr Clemes, the OHIP schedule of benefits contains the exact same services that are, in that situation, deemed insured, but in other settings the exact same service may not be an insured service.

Ms Wynne: But then it's an uninsured service, right?

Mr Bevilacqua: But when we read the legislation, that doesn't come across clearly.

Dr Clemes: I just want it to be clear that that will be the case.

Mr Bevilacqua: If you could clarify that, we would certainly feel much better about it.

Mrs Witmer: Thank you very much to the ODA for your presentation. You mentioned here on the first page that, without the opportunity to consider the amendments, it would be very difficult for you to understand if the pro-

posals are going to improve upon the existing bill. I guess we've heard a tremendous amount of concern about the drafting of this bill and even the tone of the bill, which the minister has acknowledged they didn't get right. My question to you then, because there's going to be a complete overhaul of the bill—amendments obviously; parts taken out—do you think additional hearings should be required after the amendments have been made to the bill?

Dr Clemes: We would welcome the opportunity to have the hearing in addition to being able to provide a written submission later on. Certainly, we would always welcome an opportunity to comment face-to-face with the committee.

The Chair: Thank you for appearing today. We do appreciate it.

Dr Clemes: Thank you. We appreciated the opportunity.

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COALITION OF FAMILY PHYSICIANS OF ONTARIO

The Chair: If I could call forward the 10:40 delegation, which is the Coalition of Family Physicians of Ontario, represented by Dr Douglas Mark and Dr John Tracey. Please come forward and make yourselves comfortable. Same rules as every other group we had before us today: You have 20 minutes to use any way you see fit. At the end of the presentation we will try to split up the remaining time equally amongst the three parties. If it is only a short period of time, I may assign that time to one party. The floor is yours.

Dr Douglas Mark: Good morning. My name is Dr Douglas Mark, and it is my privilege to serve as the president of the Coalition of Family Physicians of Ontario. Dr John Tracey and I are grateful to have this opportunity to share our concerns about Bill 8 with you.

The Coalition of Family Physicians is a voluntary, member-driven, grassroots organization, representing over 3,600 family physicians, that continues to grow. It is dedicated to protecting the rights and independence of family physicians across the province. We advocate, on behalf of our patients and members, solutions to improve our health care system and health care delivery to the people of Ontario. To present to you our main concerns, I wish to introduce to you the chair of the coalition's political action committee, Dr John Tracey.

Dr John Tracey: Mr Chairman, ladies and gentlemen, thank you for allowing the Coalition of Family Physicians to present our thoughts and concerns about Bill 8 to you today. My name is John Tracey. I'm a family physician in Brampton and chair of the political action committee of the Coalition of Family Physicians.

Bill 8 is a complex body of work that has widespread ramifications for our members and our health care system. We understand why the minister wants to introduce this bill, but in the process, let me explain as a prac-

titioner why this may buckle the system you are trying to protect.

The minister, in his earlier remarks, has identified key components to this bill.

Part I deals with the Ontario Quality Health Council. I wish to draw the attention of the committee to sections 4 and 6.

Some of the many functions of the health council are, under subsection 4(a), "to monitor and report to the people of Ontario on ... consumer and population health status, and ... health system outcomes."

In order to do this, there are prescribed regulations in section 6, of which I draw your attention to:

"(6) The Lieutenant Governor in Council may make regulations....

"(h) governing the transfer of information from persons provided for in the regulations of information, including personal information....

"(i) governing the confidentiality and security of information including personal information," again.

The committee is aware that there is currently a proposal to introduce health information privacy legislation, Bill 31, in this province. In the embodiment of this legislation under part IV, section 45 there is a provision that, on the request of the minister, a health information custodian shall disclose health personal information to an approved health data institute.

Notwithstanding these requirements, there is also a process of primary health care reform occurring in Ontario at this time.

It concerns us greatly to report that patients, when enrolling into family health networks and family health groups, are likely giving consent for the release of their personal health information directly to the ministry when they sign the enrolment forms.

There is concern shared by many patients that this legislation can bind a physician to releasing personal patient health information to the ministry; patients may have given consent for such release when signing an enrolment form for FHGs (family health groups) and FHNs (family health networks); and, by order of the Lieutenant Governor in Council, the quality health council may have access to this information.

Bill 31 attempts to protect the release of the information to a health science data institute for monitoring the health care system. However, there is a provision for the release of personal health information in this bill to ostensibly perform the same monitoring function through the health council.

Together there is the potential for confusion, and since there are severe penalties for wrongful release of personal health information, we are asking this committee for clarification.

Part II around accessibility: We have serious concerns here with how the bill addresses accessibility to health care services. The bill, as it stands, conveys what we can only describe as extraordinary powers to the minister and to the manager of the Ontario health insurance plan.

Section 9 imposes the OHIP schedule of benefits upon all doctors as a sort of unilateral employment contract

without any explanation or provision as to how this document is to be negotiated and agreed upon. Subsections 9(1) and (2) state that physicians shall not charge more or accept payment for more than that provided by OHIP for a particular service.

We wish to point out that in Ontario today the plan provides a fee of approximately \$24 for providing care to a patient for 24 hours—that's \$1 per hour—whilst that patient is in hospital. There are hundreds of thousands of orphan patients in this province who do not have comprehensive family care physicians and require hospitals to contract with physician hospitalists and subsidize the fees received from OHIP for hospital care. This bill has the potential to make these and similar subsidized payments illegal.

Section 9 removes a doctor's right to bill his or her patient directly for services provided. This effectively could conscript doctors to assume the role of employees, possibly changing their status under Revenue Canada, to be compensated as the ministry sees fit, since the government sets the schedule of payments independent of any proper bargaining process.

Section 10 imposes a bargaining agent selected by the minister and permits the minister to select other bargaining agents as the minister decides. There is no acknowledgement of physician rights to select their own representative agent.

We are concerned and object to the provision in this act that recognizes and entrenches in law that the sole representative body for the physicians of Ontario be chosen to be the Ontario Medical Association.

If there are later amendments to this act that provide for the removal of the necessity for individual practitioners to sign accountability contracts and require only that corporations sign these contracts, then there is considerable concern among our membership that the minister might include in the next master agreement a provision that a representative body sign a joint accountability contract on behalf of the profession as a whole.

I would point out that the Coalition of Family Physicians recently held a referendum of our membership which asked if they believed that physicians should be given the right to choose their bargaining agent. The results show that 92% of the 1,545 respondents clearly indicated that physicians should be offered a choice as to whom they wish to represent them. This is, after all, a right of every other individual in this country. Why would this act seek to impose a representative body of the minister's choice on physicians?

Having acknowledged a representative body that would enter into negotiations on behalf of physicians and having removed the rights of physicians to bill for their services, it is essential that this committee enforce the provisions of the Canada Health Act, section 12, which provide for a legal framework for negotiations and a dispute resolution mechanism that includes binding arbitration.

Section 11 sets aside the provisions of the statutory powers act and permits the manager of OHIP to make

arbitrary judgments about whether someone has made an unauthorized payment for a service. Should the manager arbitrarily decide that the service payment was unauthorized, then it empowers the manager to declare the doctor as indebted to the plan and to recoup these payments through a garnishment process from other bone fide accounts payable to the physician.

Last year physicians were regarded as heroes as, with other health care professionals, they risked their lives daily to battle SARS. This bill now seeks to criminalize our profession, not just with severe fines, but with up to 12 months' imprisonment if we are found guilty of charging a fee that is judged by the general manager of OHIP to be an inappropriate fee. Removal of jail sentences for billing misdemeanours would be viewed as a necessary priority amendment.

Section 12 limits any form of a proper review of the arbitrary decisions and actions set out in section 11. This is contrary, in our view, to the principles of natural justice.

Section 16 imposes restrictions upon or limits the charging of fees for services that are not even designated as medically necessary and thus not even part of the OHIP mandate; this, despite jurisprudence otherwise on the matter. This would include the bundling of fees for uninsured services and offering patients the opportunity to pay a one-time annual fee, otherwise known as block billing.

Section 17 imposes the penalties on individuals that contravene a provision of this part of the act. These penalties include \$50,000 fines and/or 12 months' imprisonment. Imprisonment is absolutely unacceptable to the medical profession and needs to be struck from this bill.

This bill sets out to remove the rights of certain individuals to set their fees for their intellectual property, make the minister the sole payer and, in order to be paid, demand that the individual independent service provider sign an accountability contract.

On the matter of part III, accountability, section 21 allows the minister to compel physicians, who at this time are independent contractors, to enter into an accountability agreement with the minister or other agencies as so directed. This of course begs the question of choice to enter these so-called agreements and whether these agreements are a matter of law when in fact the terms of the agreement are imposed and not negotiated.

As you may appreciate, doctors are already accountable to our patients in at least three different ways:

We are subject to strict regulation of our practices and wide-ranging scrutiny and discipline by the College of Physicians and Surgeons of Ontario. The complaints and disciplinary process grants the patient the right to present their concerns to the college at no cost to him or her.

We are subject to an extensive array of civil law penalties in the courts, akin to any other contractor.

We are subject to the discipline of the marketplace, though we do admit that the opportunities for market discipline are rapidly diminishing for our patients as doctor shortages worsen around the world.

Thus we already have three levels of accountability to our patients. This bill does not enhance a doctor's accountability to his or her patients. It attempts to make doctors accountable to another layer of bureaucracy.

Section 22 allows the minister to compel a physician to comply with a prescribed compliance measure. We have absolutely no idea what these compliance measures may be but we are concerned with the tone and intent of this section.

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Section 26 states that if a physician fails to enter into an accountability agreement, fails to comply with any terms of the agreement or fails to comply with all or part of the compliance directive, then the minister may impose the following corrective measures: a fine of not more than \$100,000; reduction, variation or discontinuation of funding; or variation of any term of any agreement or contract between the crown and the physician. These provisions have the potential to bankrupt physicians, as they have long-term lease commitments and staff contracts to meet. It is essential that these impositions be removed from the bill, as no one could possibly enter into terms of employment under these conditions.

These measures within the bill will further erode access to care for the people of Ontario. Imposition of this bill and all that it implies at this time, we are sure, will add to the pressure for physicians to seek other jurisdictions in which to practise their craft. This legislation expects physicians, who are regarded as legally independent contractors, to sign accountability contracts so that they can receive payment for their services from OHIP. How many bright young people about to begin their careers in medicine will remain in Ontario if they must sign these accountability contracts in order to be paid?

We have not made specific amendments to particular sections of this, simply because we believe that the entire bill, as it is currently constituted, is flawed and requires a complete revision. Dr Mark?

Dr Mark: One million Ontarians cannot find a family doctor. They are rightly concerned that the situation will grow worse, as 25% of family doctors are expected to retire. Ontario physicians' fees rank seventh in Canada. The numbers of trained family doctors coming out of medical school residency programs are diminishing rapidly. There is a critical shortage of doctors across the developed world. Well-trained family doctors have skills that are in great demand throughout the world. Physicians will leave Ontario or move to live and work in more hospitable environments or find other employment avenues should present trends continue unabated and unchanged.

Recruiting new graduates in a legislative environment that suspends their civil rights and liberties will indeed become a difficult travail. Indeed, the credibility of the government's commitment to the future of medicare depends upon fairness and respect. The physicians of Ontario deserve the same rights as their fellow citizens. Physicians must have the right to choose their own bargaining agent and framework for bargaining in a meaningful way with the province.

The Minister has indicated his intention to make all health system players accountable, particularly to patients. This bill is supposed to empower consumers by entrenching accountability. But accountability, in our book, is a mutual responsibility. With respect, we see little accountability by government to its doctors and, by extension, to their patients.

In our view, having scrutinized this bill in its entirety, we see little evidence of any accountability by central health ministry planners to patients. In fact, where the burgeoning health administration is concerned, accountability appears to be unidirectional, radiating out to physicians. We think that this is a serious oversight.

If this bill goes through without very significant and fundamental amendments, there will be a serious negative impact for patient accessibility to care in this province because doctors simply will choose to not practise where they do not enjoy the same rights as other citizens.

Thank you for this opportunity to present today. We would appreciate a further opportunity to present again if this is possible, after ministerial amendments are available. We would be pleased to serve on any committee that is so constituted in order to give meaningful input.

The Chair: Thank you, doctors. We've got about six minutes left, so let's start with Ms Wynne.

Ms Wynne: Thank you very much for your presentation, and thank you for your willingness to keep talking to us about these issues. I just wanted to raise a couple of points. On the issue about the transfer of information, the way the legislation is written and will be amended, the intent is not that there will be any conflict with Bill 31. I just wanted to reassure you of that. As far as the incarceration provisions go, they will be gone. I think if you look at the comments made by the minister on the first day of the hearings, he talked about the tone and that some of the provisions, some of the remedies, were harsh, and we've acknowledged that. So that will be changed.

On the larger issue of accountability, you haven't made specific suggestions about what an accountability framework might look like. This bill is designed not to deal with sole practitioners, but with organizations, institutions. Can you talk a little bit more specifically about what you think an accountability framework could look like or some of the key features of that?

Dr Tracey: I'm not qualified to do that, to be honest with you.

Ms Wynne: OK. Do you agree with the concept that there should be an accountability framework in place?

Dr Tracey: You tell me, and you define what you mean by accountability and then perhaps I could relate to your question—a little bit more than just the word "accountability."

Ms Wynne: OK. I don't know how much time we've got, but I think there's a general feeling that there's a lot of money that goes into the health care system, and I think what we're looking for is a way to track what's happening. If the government has—and we do—some general directions where we'd like to go, we can articul-

ate those in specific standards or specific directions with institutions and then talk about whether we can move in that direction and how we can do that and then hold the institutions accountable for doing that.

Mrs Witmer: Thank you very much, Dr Mark and Dr Tracey. I think this is an excellent presentation. I see that you have reached a conclusion that I would have to say I have reached as well. I do believe that the bill, as presently constituted, is fatally flawed—"fatally" is my word; "flawed" is your word—and I do believe it requires a complete revision.

I hear the government say they're going to introduce amendments, but I guess I wonder why it was necessary to introduce such an inflammatory piece of legislation with such harsh penalties and accountability only going one way. I guess my question to you would be, would it be your preference that amendments be made to this bill—and it looks to me that practically every section is going to have to be amended—or that there be a complete revision or rewrite of the bill, based on what we've been hearing?

Dr Tracey: I would be in favour of the latter, a complete rewrite, and I would also be in favour of asking for our organization to be a part of the committee or indeed have some input from the grassroots level. It seems to me that accountability for the health care system may be very virtuous, but the fact is, I ask, why do I have to lose my rights to allow this accountability process to go through? I would like the opportunity to talk more about that, and this is not the format today.

Dr Mark: I would echo those same remarks, and I'd also like to see that the legislation be worded so that it will empower us, and not restrict us, to do our jobs.

Mrs Witmer: I guess what else concerns me is I've had a flood of letters, and I'm sure others have as well—concerns from doctors. They see this as not improving accessibility. For many of them, they're once again considering moving out of this province, especially young doctors. As you've pointed out, we have many, many people in this province without a doctor, and I'll tell you, this is not a carrot to entice people to stay. That concerns me.

Dr Mark: We would agree.

Ms Martel: Thank you for being here this morning. The minister gave us some information on Thursday when we were in Windsor to indicate that solo physicians, group practices and trade unions are not going to be required to enter into accountability agreements and therefore they won't be subject to any of the provisions of Bill 3.

One of the more onerous provisions that you didn't reference that I actually thought you would under that section, had you been included, was section 29. Just to give people a flavour of where the government is heading, it's probably worth reading into the record. This is with respect to section 29, "Information":

"For the purposes of carrying out the provisions of this part"—this is accountability agreements—"the minister may require any person, entity or agency to provide the

minister with any information that the minister considers necessary, including personal information other than personal health information within the meaning of the Remedies for Organized Crime and Other Unlawful Activities Act, 2001, in such form and at such times as the minister may require" etc.

So when you talk about being concerned about some of the provisions, that one was pointed out to us by another physician in another community as being extraordinarily over the top. I think the government missed the boat by not consulting with anyone before they brought this forward. I said last week, and I'll say it again: I don't think you can fix this particular bill. I think you have to withdraw it and start again.

Let me just focus on the section around the health council, because it's interesting to me to note that the council will do a number of things, but the council will not deal with wait times. In the same regard, the minister, in getting a report from council, doesn't have to do anything about wait times either. Given what you deal with on a daily basis, what's going to happen in a bill that purports to support medicare and actually does nothing, and forces the minister to do nothing, about wait times for health care services?

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Dr Mark: I truly believe it will make wait times worse if we bring out this bill, and will cause fewer physicians to want to work in this province.

Ms Martel: We are hoping that now that physicians know they are not included—of course, we're all waiting to see the amendments—some of that concern may be relieved. If I look with respect to the council, though, they are given some responsibility, but their responsibility certainly doesn't extend to making recommendations to the minister about how to fix some of what is lacking in the health care system. Do you see a point to having another council do another report that doesn't force the minister to do anything?

Dr Mark: I think our group would agree to that. A lot of the things that are a problem in this bill seem to be things that were tried to be passed earlier in Bill 26, so if we can look back at that time and realize that there were flaws from that bill in some of the things that are introduced here, that would help future amendments to the bill. We'd be happy to review those amendments and would be happy to work within a committee to help do that as well.

The Chair: Thank you, Dr Mark and Dr Tracey, for coming today. We did appreciate it.

CANADIAN MENTAL
HEALTH ASSOCIATION,
ONTARIO DIVISION

The Chair: Our next delegation is from the Canadian Mental Health Association, Ontario division. Patti Bregman is the director of government relations.

Ms Patti Bregman: A delegation of one.

The Chair: Make yourself comfortable. Being one person, you have all of the 20 minutes to use any way you like.

Ms Bregman: I think, as usual, I'm going to try to keep it relatively brief and allow time for questions. I'm definitely not going to read my submission through, so we can have a little bit more of a discussion, because I think, as usual, mental health is a little different and we have some different concerns. We have some of the same. Maybe we have some things that we can help you think through.

In our submissions, we really focus on two main things. One is the whole issue of access to care, mental health actually being part of the health care system, which is a huge, ongoing problem. The second is the issue of accountability, and if I don't touch on that as much or as long, I don't want it taken that it's not as important to us. We have a lot of concerns in that section. I think you've heard a lot of those concerns, and I'd rather focus right now on some of the more unique issues that we're bringing to the table.

Just so you know a little bit about how we work, and this is where we may be able to help you a little, CMHA is actually a tri-level organization. We have 33 branches in Ontario that provide more than \$50 million worth of direct services, we have our provincial office, which has a mandate of knowledge transfer, and we have a national office. We are all individually incorporated, and so we actually do not have control over the 33 branches. So we have experienced some of the issues you have experienced in terms of how you do that, and I'm going to talk a little bit at the end about some of the solutions we've come up with.

I want to start with the whole issue of access to medicare, because I think this bill, which we support in principle, particularly the first section, gives us a really unique opportunity to speak about mental health in a much more meaningful way. You'll see that as I go through the first section, I talk about a case that the Supreme Court of Canada ruled on called Eldridge, which I know the former Minister of Health is quite aware of because it dealt with sign-language interpreters in the health care system. What's unique about that case, though, is that it was the first time the Supreme Court had said categorically that health care is a public good, it's something that everybody has access to, everybody is entitled to, and that there are obligations in providing that good. What was quite unique in that case is that ordinarily the charter does not apply to things like hospitals. The Supreme Court in this case said you that can't contract out that fundamental public right to health care, so in some cases hospitals may in fact be subject to the Canada Health Act.

We see in mental health a parallel. Right now, if you look at the mental health system, I've referred in here to the fact that the Canada Health Act really does not speak specifically to mental health, and we are making recommendations about some amendments you can bring forward.

There's also a provision in the Canada Health Act that says that if you are in a psychiatric facility, it is not in fact considered a hospital for the purposes of the Canada Health Act. We had a situation in Ontario recently where a young girl from Alberta needed hospitalization. She was in one of the provincial psychiatric facilities, and the Alberta government said, "Sorry. We're not paying, because it's not under the Canada Health Act." They forced this young girl to go back to Alberta without the care she needed until she got there. We think that's a very serious problem, and we really urge this government to take this opportunity to speak to mental health as being an integral part of the health care system. Prevention and the promotion of mental health need to be explicitly recognized in this bill. I think you could lead the way in Canada and really make a difference in terms of giving people access to mental health services. So I urge you to look at the specific recommendations that we've made along those lines. I can't say strongly enough that I think if we don't start doing that, the problem that Romanow identified of mental health being the orphan child of health care will continue.

Part of the reason our presentation is so different is that many of the services people use are private. It's the most privatized sector of the health care system right now. You have CMHA branches that provide services to the seriously mentally ill, which is what the government funds. If you don't have a serious mental illness and you can't get to a family doctor or a psychiatrist, you are in the private system. You are paying, on a fee-for-service basis, for a psychologist or a social worker. For an awful lot of people, that's not affordable. One of the trends we're seeing is that employers are starting to see a huge increase in costs around mental health, and we're very concerned that even the limited insurance that's there in the private system will start to cut back.

I want to move on to two very specific aspects of the Canada Health Act. One is the catastrophic drug coverage. You obviously will know we would strongly support making sure that's in the legislation. We are a little concerned that it not be solely income-tested. There are a number of drugs for mental health problems that are very, very expensive, and we need to make sure those drugs remain accessible. We're hearing more and more that it's a barrier to employment. Employers are not picking up people for employment because they don't want to pick up the drug costs. So we may have a situation where we have the working poor who will not be covered by this legislation. We'd urge you to look at amendments that will make it very clear that it's going to be based on need but that you really have a little bit broader scope.

The second area is home care. I think right now people are probably not aware that there are a number of community care access centres in this province that will not provide home care to people whose primary diagnosis is mental illness. We think that's discrimination, we think it's a very serious problem, and we think that what it's doing is increasing the hospitalization in this

province. There's a very high rate of hospitalization for mental illness. We know from research that if you can deal with people in the community, they stay at home—we actually did a little study last week on three people in the Elgin area before and after a crisis-bed program. Before the crisis-bed program, three people, 145 days in the hospital; after the program, in two years, 14 days in the hospital. That's a saving, for three people, of \$67,000. That program is probably going to shut down because there is no money. So we have a very serious problem and we need to make sure we are addressing this.

I want to move now very quickly to the accountability piece of the legislation, which everybody has talked about. We absolutely support accountability. I think it's absolutely essential. We're one of the few sectors that have no regulatory framework. We have no formal accreditation process, although we are trying very hard to get one in place, and yet we've seen this as so important that within the agreements that we sign within our own organization, we require accountability on things like making sure we have patients' rights, making sure we have financial accountability. It's absolutely essential. We've been working with the ministry on an accountability framework for mental health and we certainly want to continue working with them.

We have a couple of concerns. One is what I think you've heard from everybody else. I guess the way we would articulate it is, what's the problem you're trying to solve? It's not clear from this legislation exactly what the accountability problem is, and I think you'd be well served to try to define it a little bit more. People will be able to deal with it more if we know what it is we are to be accountable for, what the criteria are. Have it really spelled out so that there's not all of this uncertainty and that people can comply. I think what you want is a system that starts on a voluntary basis and really only goes to this extraordinary breach.

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In our agreements, what we've done, and what you may want to think about, is that we've got the requirements, we've set them out very clearly; we've negotiated these agreements. At the end of each year every board has to sign an agreement—as do we; these are mutual agreements, and I'll get to that in a minute—that they have complied with every piece of this agreement. Therefore, they are then legally bound. What we did, for the very rare occasion when there's a problem, was put in a provision about extraordinary breach. We've put in a process, people know what the process is, and it's a graduated process. If you have a problem, you start maybe with peer review so that people have an opportunity to fix the problem before you have to use heavy measures. I think that's missing from this legislation. Even in dealing with boards, if you can get something that starts from the premise that people want to do the right thing, sets it out, and then allows them to address it, then if at the end of the day they really don't address it, you may have to take some extraordinary steps.

We certainly do not support the CEO and the accountability agreement. It's an absolute nightmare for volunteer boards to not be clear as to whom the CEO is accountable for. In our sector a huge problem is, because we have so many programs that are not ministry-funded but within an agency that is ministry-funded, what do you do when, for example, you've got United Way funding and you've got Ministry of Health funding? Under this thing, is the ministry going to come in and be responsible for all of the organization's accountability, for making sure that the CEO is accountable for the United Way funding? It's not clear, and I think you're walking into a morass that you don't really want to get into. I certainly encourage you to look at that, and we're quite happy to work with the ministry on that.

Just to close and highlight our concerns around the health quality council, and it ties a bit to accountability: When we talk about the quality councils and we talk about waiting lists, you'll never hear anybody talk about mental health waiting lists. If I went to you and you had a constituent walk in and say, "I have a fatal disease and there is a 14-month waiting list," the public would be outraged. Well, in some parts of this province there are waiting lists, for people who have serious mental illness, who are suicidal, from two to five years. In at least one of the cities, in Ottawa, half the people on that waiting list have attempted suicide. This is a really serious problem, so we've made some recommendations in here about the health quality council being able to make recommendations about data collection. There is no data collection about mental health, there is no data collection about waiting lists, so I think we need to do that.

My final point goes back to the mutual obligations. We're very happy to be accountable. We think that we need to make sure the ministry is also equally accountable back. We're dealing with the situation right now, and I think it will illustrate some of the very concrete practical problems. As you all know, I'm sure, by now, we've had no funding increases in 12 years. We are accountable. This is a sector that does not run deficits. But what happens is that they're then forced to cut people off programs. That's also accountable. So you need to make sure it's not only money, but make sure the services are where they're needed and that the ministry is funding them. The second thing is that we are now being told to do another data collection system, which we're very happy to do. Do you know what? There's no money. We have services in this province, and it's not just CMHA, but other community mental health organizations, that don't have computer systems.

If you're going to impose an accountability mechanism, the ministry's obligation has to be quite clear that they also have an obligation to provide the resources that enable the organizations to meet those obligations. Otherwise, it will continue to be this one-sided type of obligation. I think what you're aiming at, and what would be very healthy, is mutual accountability and, ultimately, accountability to the public.

I'm happy to take questions.

The Chair: That's wonderful. Thank you very much. You've used up 12 minutes. So let's go with three minutes for each party, starting with Mrs Witmer.

Mrs Witmer: Thank you very much for your very comprehensive presentation, Patti. You do an outstanding job and you're a wonderful advocate for people who have need of mental health services. You've certainly pointed out here extremely well the impact that it could have on those people who rely on the government for services. My question to you would be, what are the key amendments that you will need to see before you could give your wholehearted approval to this bill?

Ms Bregman: I'm going to give you half an answer because, as you see, this is a draft and we are continuing to work on some of the other provisions; for example, public interest. But I think there really are the two core key areas. One is on making sure that medicare includes mental health. We have to see something in there, and I think it's in everybody's interests to do that. The other is to really deal with this accountability agreement and framework and to (1) take the CEO out of that picture, and (2) to see some amendments that help us understand what its purpose is, what the criteria are and what the process will be for getting things resolved so that it's a mutually acceptable and agreeable process.

Mrs Witmer: So you see that totally lacking?

Ms Bregman: Right now it's just not clear. They talk about the accountability agreement, but there's no process for appealing it. It's just very vague right now and I think it would be really well served by making it much more clear: Is it financial accountability? Is it that you have patients' rights in place?

Also, as I said before, having a process that allows you—if there is a problem, there's nothing in this act that gives the minister any authority to go to somebody and say, "Let's try and fix the problem. Would it help if we brought an expert in to help you?" I think it's just better for everybody and it would address some of the tone issues to say, "We will recognize a problem, but we're going to work with you." The goal is to make it all work, not to be confrontational. I think that was the intention, but I don't think it's reflected in the language. So it's very important to make sure that there's real clarity on that.

Mrs Witmer: OK, and I think others have referred to the fact that it is confrontational; it is heavy-handed. As I said before, the minister has acknowledged that the tone is wrong. Do you see a connection between the preamble and the actual content of the bill? Again, we've certainly heard that there's a real disconnect there.

Ms Bregman: We raised that in part, and I do think we need to make the preamble more clear. I'm also a lawyer and I have spent enough time in courts to know that there are arguments about what preambles do. So I do have some concerns about putting too much weight in a preamble, unless you say the preamble actually counts, because often it gets to court and the court says, "It's a nice interpretive tool, but it doesn't necessarily apply." So I do think there needs to be more clarity. Again, we

need to be able to reference back and say, "Here are the principles set out. How does every section relate to that preamble?" We didn't go through all of that, but I think it's very important to do that link.

Ms Martel: Thanks, Patti, for being here. Let me follow up on that. You could go through, but you wouldn't find a link, because it isn't there. That's the problem with the bill, and I'm quite candid about this. I've said on a couple of occasions that the best part of the bill is the preamble, and you might as well throw out the rest and start again, because there is no connect between the preamble and what you want for medicare, ie, getting rid of private services, including mental health and medicare etc.

To give you a very clear idea, we could come in and change the preamble so that it would specifically reference mental health in terms of medicare. But if nothing is done for the 12-year freeze on community-based organizations, tell me how this bill is going to make things better for you or your clients.

Ms Bregman: It doesn't, and that's why we raised this and said it needs to go much further. That's why I put Eldridge in, because I do think that the government needs to begin to acknowledge that this is more than something that's nice to do. This is something that I think we've now had direction from the Supreme Court of Canada on as well, that mental health can no longer be that second-class system.

What's interesting to me—you talk about the disconnect—is that we in fact had a very good meeting last week with the policy people at health about primary care and mental health. So we're having those conversations and getting it in there, but I agree with you: We need to see that reflected here so that we are sure that when people talk about primary health care, when they talk about other services, mental health is in there and it's real and it's enforceable, that people can know that it's not just the whim of any government but that they have some rights in there that other people would have.

Ms Martel: I'm not trying to catch you, but can you give us a clearer idea? I'm not interested in, and I won't support, a bill that has a glowing preamble and then nothing to support it. If you were looking at the sector that you very capably represent, what would you have to see in the body of the bill that might actually give some life to the preamble?

Ms Bregman: It's not that I don't want to answer, because I think it's a really good question, but that is something I've actually been trying to work on so that we can come up with some more amendments. So rather than try and do something quickly, we will be coming back with further submissions, and I will certainly make a note to see if we can address that when we come back.

Ms Martel: That would be helpful. I'd appreciate that.

Ms Wynne: I just want to make a couple of points, and then I think one of my colleagues, Mr Duguid, has a question.

I take your point about mental health, and specifically as it relates to catastrophic drugs and the home care issues.

I just want to point out that the reason those are included in the preamble is that this bill is to set a framework in place for the future. So it's an acknowledgement that home care and catastrophic drugs and the issues that you identified in those two particular areas are part, I think, of another conversation. Does that make sense to you?

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Ms Bregman: Actually, no, and I'll tell you the reason why. It's because what has happened with mental health is that we are always "the next conversation." The problem is that if you don't put it into this bill—and this bill is touted as the commitment to medicare. I think we have to actually see something in this bill. I understand what you're saying, but we don't need the details on catastrophic care. I think we absolutely have to have a very clear statement in here that mental health is part of all of this. The Canada Health Act absolutely needs to be included; if the Canada Health Act isn't, this government does not see a distinction between mental health and health care.

Ms Wynne: But what I was trying to get at was that you made some very specific suggestions about needs tests and so on. I don't see where that would fit in this bill. That's what I meant. That level of specificity it seems to me is part of another conversation, because what we're trying to do is put an accountability framework in place.

The second point I wanted to make was that the way the bill is written, the accountability agreement would be between the minister and the board, right? Then a performance agreement that the CEO would have to live up to is between the CEO and the board.

Ms Bregman: As long as those other pieces are taken out. We haven't seen the amendments, and I think that's the concern.

Ms Wynne: If it's clear that that's the line.

Ms Bregman: If it's clear that that's the line that they can't jump over.

Ms Wynne: OK. I'm going to let my colleague ask—

The Chair: You have just over a minute, Mr Duguid.

Mr Brad Duguid (Scarborough Centre): I probably can't do what I want to do within a minute, but I'll do my best.

You talked about what problem we were trying to solve in terms of accountability. I think one of the problems we have with the current system is trying to negotiate and move the shift over to community-based services. I think in the mental health area, more than anything else, we've seen the impact on our communities of not being able to provide the services that we need in those communities. Would you agree there is a need for accountability agreements to try to bring these shifts about?

Ms Bregman: There's no question. In fact, we support the idea of accountability. My suggestion was only, I think—people will have an easier time understanding the bill if you can just make that a little clearer. But there's no question that we are very supportive. We

deal with one of the most vulnerable populations around, who often don't have family members. They're not going to go to the media. That's why within our own organizations and with the community mental health sector, on our own we've said we're going to do this. We've started doing accreditation without anybody saying we have to do it, because if we don't watch out for that population, too often nobody else does. So absolutely accountability is essential.

The Chair: Thank you, Ms Bregman. Thanks for coming today. We did appreciate it.

ONTARIO COUNCIL OF TEACHING HOSPITALS

The Chair: Our next delegation is from the Ontario Council of Teaching Hospitals. I think we have a delegation of four people: Virginia McLaughlin, Barbara Sullivan, Tom Clossen and Mary Catherine Lindberg. It's the same rules as everybody else. You have 20 minutes to use any way you see fit. At the expiry of your presentation, we will ask you some questions on a rotating basis. If you would identify yourselves also for Hansard, it would be appreciated.

Ms Virginia McLaughlin: Thank you very much, Mr Chair. Good morning. My name is Virginia McLaughlin. I'm the chair of the board of Sunnybrook and Women's College Health Sciences Centre. I am here today with my colleagues to speak on behalf of the Ontario Council of Teaching Hospitals, also known as OCOTH. Joining me is Barbara Sullivan, who is a board member of the Hamilton Health Sciences Centre. She will assist me in presenting some of our comments on Bill 8. Also here today is Tom Clossen, at the end, who is the president and CEO of the University Health Network. Unfortunately, Mary Catherine Lindberg, who is the executive director of OCOTH, is unable to be with us, as she is unwell.

On behalf of all of the members of OCOTH, I want to thank you for the opportunity to table our general comments and observations about Bill 8, the Commitment to the Future of Medicare Act, 2003. Copies of our written brief have been submitted to the clerk. Given the time allotted for this presentation, however, we have decided to focus our oral presentation primarily around observations 4, 5, 6 and 7 as contained in the written brief. We would like to encourage you at your earliest convenience to review the brief that we have left with you.

The Ontario Council of Teaching Hospitals is a not-for-profit organization. Our organization is comprised of 22 hospitals that provide primary, secondary, tertiary and quaternary patient care, research and teaching in association with Ontario's medical schools. OCOTH members offer acute, complex continuing care and rehabilitation services and manage annual operating budgets ranging from \$25 million to \$1 billion. Collectively, teaching hospitals consume 45% of the resources spent on hospitals in this province today.

Let me begin by saying that OCOTH believes that Bill 8 is an important, defining and complex piece of proposed legislation. It signals Ontario's intention to recommit to the principles of the Canada Health Act and proposes new accountability mechanisms to strengthen governance and accountability within the health sector. We applaud these intentions and reiterate the dedication of our members to these goals. We also want to acknowledge the statement made by the minister on February 16 that helped clarify some aspects of the bill, in particular that the proposed accountability agreements will be established between the ministry and the board of directors for those health resource providers designated under the bill, and that the ministry intends to introduce amendments which will clarify the process for entering into agreements. We are hopeful that the government will remain open to further clarifying outstanding issues with respect to this bill and will make the necessary adjustments that will ensure that we have a framework within which the health care sector and the government can work together to improve accountability and system performance.

Having said this, there are two points OCOTH would like to put on the table at the outset.

First, OCOTH believes that Bill 8 is first and foremost a message to the health care system that the government is serious about finding ways to increase accountability and enhance performance within the health care sector. These goals reflect—in large part—the priorities that most health care providers in this province fundamentally agree upon. Our concerns are not about the fundamental goals and ultimate ends to be achieved.

Second, OCOTH believes that improving accountability and enhancing performance within the health care sector will only be achieved through a process of mutual agreement and partnership between the government, hospitals and health resource providers. Such a partnership will increase understanding of the opportunities, risks and benefits of the proposed mechanisms outlined in the bill to increase two-way accountability and to ensure the flexibility that is required given the diverse nature of communities across Ontario, the hospitals which serve people in those communities, and the multi-faceted range of services offered by hospitals throughout the province.

Keeping these general comments in mind, I would now like to ask Barbara Sullivan to review with you some of OCOTH's specific observations with respect to Bill 8.

Ms Barbara Sullivan: As Virginia has already mentioned, I will focus most of my remarks on observations 4, 5, 6 and 7, which are included in your written brief. I will take just a minute to comment briefly on the first three observations outlined in that brief.

Observation 1: OCOTH supports the establishment of the proposed Ontario Quality Health Council and the role it will have in reporting on progress within the health system. Its independence from government and providers is important.

At the outset of the council's work, however, we hope that there will be an appropriate mechanism to ensure that the expertise and experience of the hospital sector—both board and administration—are available to the council. The government may want to include specific regulations under the bill that would enable the council to establish advisory committees and give it the power to access resources necessary for its work.

The role of the council may also be too limited as it's currently proposed. We recommend that the mandate of the council be strengthened to give it the ability to make recommendations based on the information it has collected and reviewed.

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Observation 2: With respect to the accessibility provisions outlined in part II of the bill and the physician payment provisions in part IV, OCOTH is concerned that these sections may potentially prohibit payment of hospitalists, laboratory physicians and other types of physicians to which hospitals make direct payments for insured services. Paradoxically, this provision may have the effect of reducing access to health care services. This section should be amended to allow hospitals to continue to make these necessary payments to physicians. I also want to note that alternate payment plans for physicians are becoming the norm in teaching hospitals in many specialties and, in some cases, throughout hospital operations. Such plans are negotiated directly within the hospital with its physician cohort, along with Ministry of Health participation, and not through the Ontario Medical Association, and are put into place through mutual agreement. While the regulations under the Health Insurance Act provide for such plans, the provisions of Bill 8 appear to remove such payment options.

Observation 3: OCOTH believes that the bill must make explicit the mutual accountability of government and providers. Despite the reference to shared and collective responsibilities, Bill 8 does not facilitate the enhanced two-way accountability needed to achieve the goals to which it aspires. The bill focuses exclusively on how to make health resource providers accountable to the government, yet it is silent on the government's obligations with respect to its support for the provision of health care. If hospitals are to be held accountable for delivering a certain level, availability and quality of care, then to what extent will government be accountable for funding that level, availability and quality of care?

I'd like to turn now to some of the specifics related to observations 4, 5, 6 and 7, which are dealt with in greater detail in our brief.

Observation 4: This relates to part III of the bill, accountability. While OCOTH accepts the principle of accountability in health care delivery, we cannot support part III of the bill as it is currently presented.

The policy contemplated in part III is a complete reversal of principles upon which accountability in Ontario's public hospitals is now ensured. At present, most public hospitals and most teaching hospitals are corporations composed of members who, generally, represent

the larger community served by the hospital, a board of directors chosen by and responsible to the members, and senior executive staff chosen by and responsible to the board. Directors are under a legal obligation to act prudently and with skill in the best interests of the hospital and its patients. The community and the ministry are entitled to look to the board and the CEO for the proper management of the hospital. If the board fails in its duty, the minister has authority under the Public Hospitals Act to investigate and, if necessary, to supervise a public hospital. To date, this approach reflects a sensible and workable balance. Initial responsibility rests with the board representing the community, safeguarded by the power of the minister to intervene if, for any reason, the board fails in its duty.

Sections 21 and 22 reverse this long-standing and successful policy. By imposing accountability agreements with hospital corporations, the minister now takes on primary responsibility for the performance of the hospital. Hospital boards would no longer have a meaningful role. However, the legal obligations of directors—that is, responsibility for hospital performance—would remain. Bill 8 does not relieve them of those obligations.

Under Bill 8, as currently written, directors have no power to negotiate accountability agreements and reduced or no power over key decisions relating to senior staffing. In these circumstances, any prudent director would be well advised to resign. We expect it would be difficult to find qualified directors to serve.

The absence of an involved, dedicated board would have an immediate adverse effect on fundraising. Fundraising, and most particularly fundraising for research, is absolutely critical for teaching hospitals. In teaching hospitals, research, education and clinical care are inextricably linked. A cutback in research funding will adversely affect clinical care and education, with enormous adverse effects on the health care system as a whole.

Our second objection to part III is to the proposed means whereby the principle of accountability is to be implemented. Sections 21 and 22 empower the minister to direct health resource providers, such as hospital corporations and other prescribed persons, which may include those exercising an executive function or position, to enter into accountability agreements. Where they fail to enter into an accountability agreement, the minister may issue compliance directives. Generally, agreements are understood to be consensual in nature. It is contradictory to impose an agreement. It's also contrary to the principles governing agreements to provide for enforcement of agreements by creating offence provisions under the Provincial Offences Act.

Section 27 permits the minister to order material changes in a CEO's terms of employment, including reductions in benefits and compensation, without any contractual recourse. This is a provision which is virtually unique in employment relations. No complex organization can expect to retain competent, capable CEOs under these conditions.

In summary, the policy proposed in part III and the means for its implementation will not have a positive effect. We are convinced that the effect of part III will in fact be substantially negative. We strongly recommend that part III be substantially reworked. Accountability can be achieved by far better means.

Observation 5: We want to speak to current efforts to advance our health system through collaborative initiatives. If implemented in its current form, the bill could seriously undermine progress that has been made in recent projects that have been undertaken jointly between the government and hospitals. For the past several months, for instance, OCOTH and the Ontario Hospital Association have been working with the joint policy and planning committee, the JPPC, on multi-year funding and hospital performance agreement initiatives. We understood that these initiatives were part of a mutual, collaborative commitment to develop stronger planning and accountability mechanisms within the hospital sector. We thought we were, together, on the right track. We believe, however, that much of what is being proposed in Bill 8 compromises the progress that has been made to date.

Observation 6: The current emphasis of the bill reinforces individual accountability of hospitals and other health resource providers. This focus may promote a greater inward concentration at the expense of moving the health care sector toward greater integration and systemization. This contradicts many other policy goals and directions in recent years that have called for strengthened system accountability.

A serious concern among teaching hospitals is that this bill may have an adverse impact on current voluntary discussions that are taking place to streamline service delivery in a number of communities across Ontario. In fact, there appears to be a critical disconnect between what's being proposed in this bill and the efforts currently underway to streamline and integrate clinical services as well as support services across and beyond individual organizations.

Our suggestion: Rather than government becoming directly involved in the governance and management of hospitals, OCOTH proposes that accountability be strengthened by holding hospital boards accountable to the government and the communities they serve through regular reporting on performance based on a series of overarching principles developed and mutually agreed upon between both parties—that is, hospitals and government. These principles would form part of a template that specifies in broad terms what the expectations with respect to service delivery and accountability will be for both parties. Examples of the kinds of principles that could be included in a template are outlined in our written brief.

Observation 7: Finally, OCOTH members are concerned that the bill raises a number of questions that may, at least in the short term, be difficult to grapple with. For example, it's important that service or accountability agreements be negotiated within the context of clearly defined and articulated provincial service levels predicted

through the use of knowledgeable data and experience in the field by hospitals and health providers themselves. To reduce uncertainty and facilitate planning, the agreements will have to be negotiated in a timely manner. We're uncertain about the possibility of achieving individual and distinct accountability agreements with each of the province's hospitals in a timely way, given that each hospital serves a different community and that teaching hospitals have particularly complex mandates.

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In conclusion, I want to re-emphasize that although the preamble of Bill 8 articulates specific goals that are strongly supported by OCOTH, we have reservations about the effectiveness of the strategy and mechanisms for achieving those goals as presented in the bill.

We support legislation that commits to the future of medicare in this province and puts in place instruments to help achieve the goals of greater accountability and enhanced performance. Achieving these goals should not be addressed through arbitrarily altering governance structures; rather, there should be a strategy that encourages government and health resource providers to come together to develop the underlying principles needed to set common objectives, expected outcomes, targets for achievement and performance measures.

We must move toward excellence in our health care system by building on our strengths. Together we should seek first and always to catalyze and support positive, voluntary and mutually acceptable changes and progress. We are very anxious to work with government to achieve that.

The Chair: Thank you, Ms Sullivan. It was very well presented but you've left us with about one minute. We're going to let Ms Martel have that whole minute.

Ms Martel: Very briefly, last week the minister gave us some indication of where he plans to move with part III, which gives me no comfort at all. It says very clearly that the minister can still issue a compliance directive or an order. It says that CEO compensation clawback can be considered by the minister and it also says that section 27, as you pointed out, does apply to a CEO.

Tell me, do your concerns change with respect to part III, given the revised changes that the minister outlined to this committee on Thursday?

Ms McLaughlin: No.

Ms Martel: Thank you. That says it all.

The Chair: Thank you very much for coming today. Thanks for the presentation. We appreciate it.

CENTRE FOR ADDICTION AND MENTAL HEALTH

The Chair: Our next presentation is from the Centre for Addiction and Mental Health, Dr Paul Garfinkel, president and CEO, and Gail Czukar, executive vice-president, policy and planning. Make yourself comfortable. You have 20 minutes. You can use that time any way you like. If at the end of the presentation there is any

time left over, we will share that among the three parties if it's a substantial amount of time. The floor is yours.

Dr Paul Garfinkel: Thank you very much for the opportunity to speak with you today. By way of introduction, the Centre for Addiction and Mental Health was created in 1998 through the merger of the Donwood Institute, the Addiction Research Foundation, the Clarke Institute of Psychiatry and the Queen Street Mental Health Centre.

CAMH assumed the various responsibilities of these four organizations with a provincial mandate for care, research, education, public policy, health promotion and prevention throughout Ontario. We deliver these services through our main sites here in Toronto and through 26 satellite offices throughout Ontario.

We have made it a priority to promote positive change in government policy for people with mental illness and addiction.

With regard to our response to Bill 8 concerning medicare and its values, we are very pleased that the preamble to the bill affirms the system of publicly funded health services as fundamental to Canadian values. However, mental health and addiction services are often not explicitly recognized as an integral part of this system, despite the prominence of mental illness and addictions and their severe complications and cost to our society.

If one looks at the Canada Health Act, it specifically excludes "a hospital or institution primarily for the mentally disordered" from the definition of hospital. This is offensive and discriminatory and should not remain part of our law or our medicare system. Although Ontario funds these services, not all other provinces do, and this is not acceptable.

We ask that the preamble to Bill 8 explicitly recognize that all Ontarians who have physical or mental illnesses are entitled to the equal benefit of publicly funded health services, according to their needs.

The fourth point of the preamble should ensure access based on need, not ability to pay nor whether a person has a physical or mental illness.

We believe that mental health and addictions problems must be served by accessible, effective and adequately funded programs for all people who need help. A wide range of services is needed to improve and maintain mental health.

CAMH supports the creation of a health quality council to monitor and report on the issues of access to publicly funded services, utilization of resources, consumer and population health status and health system outcomes. CAMH specifically supports reporting on these issues in the mental health and addictions sector, and we want to help to develop the technologies and the processes to improve these measures. Such information will create better transparency in the sector and will help all Ontarians to better understand our publicly funded system.

CAMH supports the Canada Health Act's principles of comprehensiveness, accessibility, portability, universality and public administration and ask that you consider these principles in terms of the communities we serve.

We are especially concerned about potential defunding of addictions services. This comes up repeatedly in a recurrent fashion in our society because of the extreme stigmatizing attitudes people often hold to this population. We would ask that you support actions that increase access to mental health and addictions services.

With regard to the section on accountability, CAMH supports the government's initiative to identify opportunities for greater accountability. We acknowledge that there are strengths and real weaknesses in the current accountability framework. There is lots of room for improvement. We urge that the principles of consultation, collaboration, transparency and the public interest should guide the development of any new accountability arrangements.

Ministry expectations for hospital performance and health care outcomes must be clarified and developed, but this must be done in consultation and with agreement of the hospitals.

Together with government, we must develop unique indicators and measurement tools for the mental health and addictions sector. The indicators and measures used in the acute care sector are of limited value to our population. For example, length of stay in the acute care sector may be a very valid indicator. In our sector, length of stay in a hospital, if the person is going out to an inadequate support system, is a very poor measure.

New accountability arrangements introduced through legislation must not undermine the role and responsibilities of hospital boards. I think you just heard from OCOTH on that quite eloquently. Any new accountability arrangements should be made with the hospital boards and not directly with hospital staff.

We do, however, support the government's efforts to develop a wide range of accountability mechanisms that are graduated in their approach, starting with the most mild and working up to more definitive mechanisms with the hospital board, not the CEO.

We would suggest that much more use could be made of the role of auditors in clarifying reporting obligations of the health care facility through the board, and through the board to the ministry. It is the board's responsibility to hold the CEO and other senior staff accountable.

As drafted in Bill 8, there would be an opportunity for broader disclosure of personal information from hospitals to the minister and the general manager of OHIP. This is quite different from Bill 31, the Personal Health Information Protection Act, currently under consideration by the Legislature.

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We're pleased that the minister has indicated that he will introduce amendments to this bill to delete the minister's authority to directly collect and use personal information. It is very important that we see how this drafting proceeds.

Further, in accord with what OCOTH just mentioned, the accessibility rules in section 9 of this bill could have an unintended consequence of restricting health services by prohibiting hospitals from making necessary direct

payment to physicians. This is extremely important to us, because not all mental health services from physicians are funded through OHIP; there is direct hospital payment that has to occur. We welcome the opportunity to work collaboratively with the government to discuss mutually agreeable alternatives that ensure our clients continue to receive accessible services.

Further, we're concerned that Bill 8 leaves significant details to be determined in the regulations. We urge the government to include the proposed 60-day consultation prior to the passing of the regulations under this legislation. This consultation should not be restricted to a few major stakeholder groups that represent the traditional interests in our health care system.

We look forward to working collaboratively with the government to find solutions to these kinds of problems.

In conclusion, CAMH recommends the following:

First, change the preamble to recognize the importance of mental health and addiction services in the publicly funded health system, recognizing that these services are essential for the mental and physical health of Ontarians.

Second, the government should create the health quality council and give it a specific mandate to ensure that it studies and reports on the mental health and addictions sector.

Third, in developing new accountability arrangements, the government should be guided by the principles of consultation, collaboration, transparency and acting in the public interest.

Fourth, the government should continue the dialogue with hospitals and our associations to develop the appropriate accountability structures. These must acknowledge the role and responsibility of hospital boards and the mutual obligations of health service providers and the government to achieving increased accountability.

Fifth, the provisions dealing with disclosure of personal information to the minister must be redrafted, in keeping with the proposed model for disclosure in schedule 1 to Bill 31.

Sixth, the government must work collaboratively with the stakeholders to discuss mutually agreeable alternatives to section 9 to ensure that access to health services is not unintentionally limited.

Seventh, that a provision be added to the legislation to require public consultation prior to passing the regulations under this legislation.

As you consider this legislation and prepare to table amendments, please consider our recommendations and the need to protect and support Ontario's mental health and addictions communities.

Thank you again for the opportunity to speak to this legislation. We welcome any questions or comments you may have.

The Chair: Thank you, Dr Garfinkel. You've left us with about nine minutes, which is wonderful. Three minutes for each party, starting this time with Ms Wynne.

Ms Wynne: Thank you for your presentation. I certainly take your point about the particular needs of the mental health population. I just want to make a couple of comments and I've got one question.

When you talk about the development of new accountability arrangements, I wanted to let you know that sections 21 and 22 will be amended to be clearer about what those arrangements will be, OK? That's an issue that's been raised by a number of presenters, and the amendments will include notice and other due process provisions so that it's clear exactly what the process is.

You also made a point about the need for unique indicators, depending on the institution or depending on the area. It's not the intention that there will be one accountability agreement for everybody. That's where the discussion and the negotiation and renegotiation come in. Again, that's what will be clarified in those amendments.

You talked about section 9 and working collaboratively with stakeholders, and I think, again, that's a section that is going to be amended.

Having said all of that, this is a question that was asked earlier about the need to provide more support to community health. If the intention and the direction of this government are to move toward that reality where there is more support for community health services, which has a direct impact on the provision of service for mental health providers, do you see this bill as a step in that direction in terms of making sure that there is accountability within the existing system? Do you see that this will help us move toward that more community-based model?

Dr Garfinkel: There's no question that increased accountability in the health sector is very important. We recognize how important this is for all of us. There are some strengths in the current model, but there's a long way to go. In our sector, and I personally believe in the entire health sector, the arbitrary distinction between institution and community is very artificial, and we should be considering holistic, integrated approaches to health care. I do think efforts to increase accountability are highly valued and we should be pursuing them. As I mentioned, I think the mutual discussions with the boards, the mutual agreement with boards, are extremely important.

Ms Wynne: So that mutuality; yes, we need to get that in. Do you also see that it would be useful to have accountability agreements that were synchronized among a group of providers?

Dr Garfinkel: I do worry. That's an important question. One of the big problems we have in our sector, and in all of health care, are the silos of care. We could unintentionally make the silos a little bit stronger than they are even today.

Ms Wynne: If we focused on individual agreements. So you see—

The Chair: Thank you, Dr Garfinkel. We go to Ms Witmer.

Mrs Witmer: Good to see you, Dr Garfinkel, and also you, Ms Czukar. I thank you for your very thoughtful and insightful presentation. You've certainly provided a total overview regarding the concerns you have with the legislation, and also made some good recommendations

for improvement. I would ask you, what are the key amendments that you believe must be made before you could support this bill?

Dr Garfinkel: I think they reflect the nature of the accountability agreement and a contract that's mutually agreed that occurs with the board that has a graduated series of intrusions. The issues about privacy and how privacy is handled, the issues of physician payment—I think you and I have had this discussion before. I feel that the way the mentally ill have been historically treated in Canada is offensive, and it relates to stigma and it relates to the fact that governments directly controlled our hospitals before, and I would very much like to see something in the preamble correcting that. Gail may have—

Ms Gail Czukar: I would support that. I was going to say, in response to the last set of questions, that I hoped the indication that the unique indicators about mental health would be incorporated into the agreements isn't to say that the issues we've raised about including mental health in the preamble won't be done. We feel it's very important to create the right stage for it. I think the CMHA appeared earlier and said that mental health is always going to be the next conversation; it's not the one we're having now, and we'd like to see it now.

Mrs Witmer: When I take a look at your presentation, I recognize with sincere regret the fact that we've made so little progress. We've been having this conversation for a long time, and I don't think we can afford to postpone the conversation any longer. I certainly hope that the government would very seriously consider including, as you have asked in the preamble, that all Ontarians who have mental or physical illnesses are entitled to the equal benefit of publicly funded health services. I think that's extremely important and I don't think we can continue to delay the conversation. We've been putting off this conversation for many years. We both know that. We've made some progress, but you're right: There's still a stigma that continues to be there. You reminded me of the fact that in the Canada Health Act, a hospital or institution primarily for the mentally disordered is excluded from the definition of "hospitals." That just shows you about what has happened throughout the entire province.

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I thank you for your presentation. I trust that the government will pay heed to what you've recommended in the way of accountability arrangements. But I'm appalled, because this bill should have been a white paper. We've heard that part III is totally wrong, the preamble is wrong, there's so much wrong and there are so many flaws. I think, for the sake of all the stakeholders, many who are terrified of the implications, the government would have been better served to have had a white paper, gotten input from groups such as yourself and come forward. Once amendments are made to this bill, if that's how the government chooses to go as opposed to withdrawing the bill, do you think that additional hearings are going to be required to deal with the amendments, which are going to be very substantial?

The Chair: An extremely brief answer.

Dr Garfinkel: Yes.

Ms Martel: I thank you both for being here. It'll be no surprise to you that I'm going to go back to the accountability agreements. The government might lead you to believe that this section has been cleaned up in response to concerns. I think it's worthwhile reading into the record exactly what the minister, through his parliamentary assistant, gave to us last Thursday. Here are sections 22 and 23, which are the sections you're worried about. Section 22 reads, "Include notice and other due process provisions, including time frames for notice, to address development of accountability agreements, issuance of compliance directives and orders (eg discussion process, meetings, exchange of documents/information, representations that the minister has to consider before issuing a compliance directive or an order)." That's what the new proposed section says.

Let me give you section 23 as well, because you've made it very clear that it's the board's responsibility to hold the CEO and other senior staff accountable. Here's what the proposal from the minister says about section 23: "Include a range of remedies directly in legislation that could be issued in a compliance directive or an order to address non-compliance (eg audit, budget review etc). CEO compensation clawback or any other financial remedies to be applied to a CEO as a last resort only after all due process has been exhausted and in exceptional circumstances."

I'm sorry; I haven't seen the amendments, but enough of what I've seen and what the minister intends to do leads me to believe that there has been very little change, and the government hasn't got the message yet, because the government is still, through the minister, going to deal with the CEO and compensation, and the government is still, through the minister, going to issue compliance agreements and orders. That doesn't speak to consultation and collaboration and agreement to me. Are your concerns resolved?

Dr Garfinkel: They're not resolved. I think there has been some improvement from what I heard before. It has a way to go yet.

Ms Martel: Do you think, when the minister still has some sweeping, draconian powers to issue directives and to issue orders, that the tone is going to change in terms of the ministries working with not only your board, but boards of other institutions across the province?

Dr Garfinkel: I believe this has to be a collaborative process. But as I said, there should be gradations in what government can do, and I think those gradations have to be clarified and known to all of us. We're not there yet.

The Chair: Thank you for coming today. We certainly did appreciate it.

Dr Garfinkel: A pleasure.

The Chair: We can move on now to the last group before we recess for lunch. Oh, two more groups before we recess for lunch—sorry to get everybody's stomach going there. Everybody might want to check their phones, while we're moving around, and make sure they're on vibrate or on silent.

CATHOLIC HEALTH CORP OF ONTARIO

The Chair: The next delegation is the Catholic Health Corp of Ontario, represented this morning by Don McDermott, the president; Mark O'Regan, the vice-chair of the board; and Sister Sarah Quackenbush, the vice-president. You have 20 minutes to use any way you see fit. If there's any time left after the presentation, we'll split your time up amongst the parties.

Mr Mark O'Regan: Good afternoon. I am Mark O'Regan, vice-chair of the Catholic Health Corp of Ontario and a former chair of the St Joseph's Health Centre here in Toronto.

Sister Sarah is the vice-president of the CHCO and a former CEO of St Joseph's Hospital in Elliot Lake. Don McDermott, as mentioned, is the president of CHCO and also a former chief executive officer of St Joseph's in Sarnia.

Following my opening remarks, Sister Sarah will deliver our message, and thereafter Don will receive your questions to close out our time with you. Our chairperson, Sister Winnifred, was unable to be with us today. On her behalf, we thank you for this opportunity to appear before you as you consider Bill 8, the Commitment to the Future of Medicare Act, 2003. We are the sponsoring organization for 13 Catholic health institutions—acute, long-term care and homes for the aged—in the province.

The Catholic Health Corp of Ontario was incorporated under the Ontario Corporations Act in 1998 and includes as members the Sisters of St Joseph, Toronto; the Sisters of St Joseph, Sault Ste Marie; the Grey Sisters of the Immaculate Conception, Pembroke; and the Sisters of Charity of Ottawa. These congregations provided an initial fund to support the operational costs of sponsorship provided by the CHCO.

The purpose of the Catholic Health Corp of Ontario is to sponsor Catholic health institutions in Ontario. Within the Catholic Church, for an organization to carry on its work in the name of the church, it must have a sponsor to ensure its work is done within the values of the church. As the congregations of sisters move to other works, this corporation accepts sponsorship of the health institutions formerly founded and sponsored by the sisters. The sisters retain ownership of the institutional property.

These institutions sponsored by the CHCO are separately incorporated and include Providence Centre in Toronto, St Joseph's Health Centre in Toronto, St Michael's Hospital in Toronto, Penetanguishene General Hospital in Penetanguishene, St Joseph's Care Group in Thunder Bay, St Joseph's General Hospital in Elliot Lake, St Joseph's Health Centre in Sudbury, St Joseph's Villa in Sudbury, Marianhill Home in Pembroke, Pembroke General Hospital, Mattawa General Hospital, Sisters of Charity of Ottawa Hospital, and St Patrick's Home in Ottawa.

These institutions represent approximately \$770 million in operating budgets, 929 acute care beds, and 2,600 long-term-care, rehab and psychiatric beds, governed by over 180 volunteer directors.

With that, I'd like to turn it over to Sister Sarah.

Sister Sarah Quackenbush: On behalf of the sister-owners of these institutions, the operational governance of these institutions is delegated to the voluntary institutional boards. These directors are drawn from the communities where the institutions are located and represent the diverse nature of the communities, including ethnicity and religion, with the expertise required to govern a health care institution. All support the mission and values of a faith-based approach to provision of health care within canon law and the laws and standards set out by the Ontario and Canadian governments.

We recognize and agree with the intent of this bill to ensure accountability within the health system of Ontario and to preserve and ensure quality health care for the patients and clients requiring these services. We agree with the tenets of the Canada Health Act, including public administration that is accountable to the people.

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Faith-based institutions such as ours strive to provide holistic care that not only includes physical and psycho-social services to maintain health and treat illness but, as well, and equally important, to provide spiritual care for those of our patients and residents who wish these services.

Because Ontario is so ethnically diverse, with many cultures and beliefs, our aim is to ensure high-quality health care regardless of religion, culture, ethnicity or economic status. We work hard to make our patients and residents feel comfortable and supported within their own religious and cultural context while getting care in our institutions. We do this through our local voluntary governing boards, which represent diversity of culture and religion in the community.

The section in Bill 8 where we have our greatest concern is in part III, on accountability. Although the Minister of Health has stated that he is willing to make changes to this section, we remain concerned that contracts with the institutions and with the institutions' executives would directly interfere with the governance process of the institutions and therefore our Catholic identity and the faith-based nature of our institutions. The compliance directives, as currently described in the proposed bill, are also direct interference with the voluntary governance process that has worked so well in this province.

The most important point we want to make is that it is crucially important that the board be the sole employer of the CEO of the institution and other senior staff so that there will be no confusion as to the terms of their working arrangement and accountability. Any interference with this direct working relationship would create confusion and undermine the board's role in the executive oversight, not just for the governance process but for ensuring that the institution fulfills its obligations of providing services based on religious values and mission. Contracting with the CEO and others in any way, including penalties imposed by the government or changes to the terms of an existing personal contract, would con-

stitute interference with the employer-employee relationship and would, in fact, decrease accountability through confusion as to who is the employer.

Another point that we feel has to be emphasized is that we recommend that the provision for service contracts with institutions and the institutions' executive should be deleted, and in its place create, with the input of organizations such as the Catholic Health Association of Ontario and the Ontario Hospital Association, clear expectations of service provision for both the institutions and their governing boards. These expectations should be negotiated and bilateral. They should identify the roles and levels of services the institutions would provide within their areas of expertise, expectations for working relationships with other institutions, and the standards of care expected. There would need to be clear understanding of the rights of religious institutions to work within their mission and values.

Within these expectations there would, out of necessity, be mutual agreement as to the financial support provided by the Ministry of Health for the institution to perform these roles within the standards expected over a multi-year time frame.

Should there be disagreement around the interpretation of these expectations, there would need to be a disputes resolution process. An objective third party is recommended to ensure fairness and equitability. If dispute is centred on the religious mission and values of the institution, it should fall to the bishop of the diocese within which the institution is located to determine the ability of the institution to comply within their canon law.

We agree with the concept of holding the voluntary boards accountable for the care provided by the institutions. However, the current Public Hospitals Act of Ontario contains a good-faith clause whereby directors are protected from negative consequences of acts or omissions if done in good faith. The ability to obtain and hold high-quality expertise at our local board levels in health care institutions in Ontario will depend on this continued protection.

Mr Don McDermott: Not only should there be clear expectations outlined that all parties agree with, but also educational programs should be required to encourage and develop expertise in the governance of health institutions. The Ontario Hospital Association and the Catholic Health Association of Ontario do excellent work already in this area of orientation and education for hospitals, and we, the Catholic Health Corp, provide on-site orientation for our new board members and senior staff in their roles as institutional faith-based leaders.

Regular assessment of compliance with expectations is necessary within fair and understandable guidelines to ensure good governance. Board evaluations with indicators and standards are available and should be required on a regular basis. Public voluntary boards need education, standards and assessment to build the best boards possible. Within our Catholic institutions, we encourage regular assessments of service outcomes, including both quality patient care and staff performance, that reflect our

values. This same approach could be used for other aspects of service similar to those provided by the Canadian Council on Hospital Accreditation.

Achieving standards beyond a certain level of excellence should be rewarded to encourage the diligence and hard work required for this level of governance. Any program and service expectations, as well as their assessment, would, out of necessity, need to be provided locally throughout Ontario. Institutions such as ours are located across the province and as far north as Thunder Bay and Elliot Lake. Each would require on-site orientations, education and assessment for the directors to avoid excessive travel and accommodation expenses.

I hope that these remarks provide you with an outline of our concerns: that contracts between institutional boards, their executives and government could interfere with the voluntary governance process, especially with faith-based institutions; that directors need to have good faith protection from legal actions continued; that clear expectations of roles and performance, negotiated with the institutions and with positive incentives, are more conducive to co-operation; that education, orientation and assessment of governance, including adherence to mission and values, are currently done in some institutions with success and are recommended as part of the public accountability process; and that the voluntary governance process, with clear lines of accountability to the CEO, is important to the Catholic institutions we sponsor, where the directors support and foster the spiritual side of health care.

Thank you again for this opportunity, and we would be pleased to answer any questions you may have.

The Chair: Thank you very much. It looks like you used up about 11 minutes, which leaves each of the parties three minutes.

Mrs Witmer: Thank you very much for your presentation. Certainly I have always valued and appreciated the role of the Catholic Health Corp here in the province of Ontario and the work you do.

I guess you've answered one of the questions which we wondered about, and that is, although the minister has made some suggestions as to changes that might be made, we don't know what those changes might be. Obviously, he is going to continue to move forward in a way where the accountability will continue to go just one way.

You've really pointed out here, I think, very well that this would in particular have an impact on the Catholic organizations and interfere with the voluntary governance process that has worked well in this province. This will be difficult for you to answer, but do you see this as a step in removing voluntary boards from having any jurisdiction within your organizations? Is this what the impact could be at the end of the day? Would you find that you don't have people who are willing to serve if this is going to be the relationship?

Mr McDermott: A lot of our board members come to us and work with us at our institutional level with the understanding that they work within certainly a faith-

based perspective, but as well, that they have the right and breadth to govern. Any loss of that kind of responsibility, I think, would result in a lot of our directors not willing to sit on boards and try and help their local communities.

Mrs Witmer: So if that's the case, what is it that specifically you need to ensure that the concept of voluntary governance, as it presently is constituted, would be preserved, as well as the institutions that you're responsible for?

Mr McDermott: This bill, I think, is a great opportunity to fundamentally support the public governance process. Recognizing faith-based institutions within that framework in fact, we feel, detracts from that, takes away from that whole public governance process.

We're very lucky in Ontario. Looking at the other provinces where this remains a fact, looking at individual institutions and public governance, we should be building on that. I think it's a great asset for the province.

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Ms Martel: Thank you for being here this morning. As an aside, I was at the opening of the villa two weeks ago. It was a pleasure, and the building is marvellous, so congratulations on that.

Let me ask you this: Is the corporation participating, as a corporation, in the joint policy and planning committee with the Ministry of Health?

Mr McDermott: Through the OHA we have input.

Ms Martel: I ask that for this reason: I have yet to figure out why the minister and the government thought it necessary to come forward with such sweeping and, frankly, draconian powers to take out boards, take out CEOs etc. As I see it, with the work that's going on right now—you're taken into that work through the OHA—that will develop performance agreements, and with the existing Public Hospitals Act, which talks about public interest, which has a protection for directors, it seems to me that the government has at its disposal a mechanism both to set performance agreements and, second, to deal with any hospitals that are out of control, for lack of a better word. I can't understand where this current motivation comes from, because the powers are very sweeping; they're very broad. You're absolutely right: Directors would be crazy to sit under any circumstance with the liability that they might be affected by, and CEOs would also feel very compromised.

Do you have any understanding in any of the discussions you might have had with the ministry or with the minister or anybody else related to this why the government thought it necessary to move forward with these kind of sledgehammer provisions when, in fact, some of their current processes, along with the current act, probably would have allowed them to get to the very same objective and the same goal?

Mr McDermott: No, I don't have an idea.

Ms Wynne: Thank you very much for taking part in this process. Bringing out a bill after first reading means that there is lots of opportunity for change and amendment. I just wanted to highlight the amendments that are

going to be made around the governance issues in the accountability section, which is where you are concerned.

But, I have a specific question. The way the accountability agreements are going to work—because they will be between the minister or the ministry and the boards and then there will be a performance agreement between the board and the CEO. But you make a statement about the interference with the voluntary governance process, "especially with faith-based institutions." Can you give us an example—because this issue has been raised, and we understand there needs to be more clarity—of what in particular a faith-based institution would be concerned about, as opposed to any other organization with a volunteer board?

Mr McDermott: Sure. As sponsors, we're responsible, essentially, to the church for our institutions' adhering to mission and values. If there's an accountability agreement that would somehow interfere with the mission and values as stated by the institution, then it would essentially negate our ability to perform that function and would, in essence, interfere with the institution's right and ability to identify itself as a Catholic institution.

Ms Wynne: OK, because I don't think this legislation is written and is certainly not intended to interfere with mission and values. Is there a specific area that you're worried about intrusion into?

Mr McDermott: Specifically at the moment, no. I think we would have to see the regulations or the next draft of this bill. But what we want to do is alert the committee that we do have that concern and that it's very necessary that faith-based institutions have the freedom to continue on in adherence to their mission and values.

Sister Sarah: I guess the concern, if we have service arrangements or service agreements, is that we don't know what that means, as Don has said. If we were in an agreement that we could not support because of our Catholic ethics guide that we have to comply to and our canon law, and if we're forced to go into any agreements without proper consultation first, it could compromise who we are and what we do.

Ms Wynne: Well, we will probably have to talk about that further, but there will be laid out what the time frame would be for negotiating those agreements and discussing what would be in those agreements. That's certainly the amendment we're bringing forward.

The Chair: Thank you for being here today. We certainly appreciated it.

ONTARIO ASSOCIATION OF COMMUNITY CARE ACCESS CENTRES

The Chair: Now we have the last group before lunch. I call forward the Ontario Association of Community Care Access Centres, represented today by Georgina White, policy adviser; Wes Libbey, board chair of the eastern counties; and Heinz Schweinbenz, board chair of the Halton CCAC.

Welcome. The floor is yours. You have 20 minutes. You can use that any way you see fit. Any time left over will be split amongst the three parties.

Mr Wes Libbey: Thank you very much, Mr Chair. My name is Wes Libbey, and I'm also past chair of the Ontario Association of Community Care Access Centres. As you pointed out, I'm currently the chair of the CCAC for the eastern counties. Accompanying me today is Heinz Schweinbenz, who is the chair of the Halton Community Care Access Centre, and our policy adviser, Georgina White. On behalf of our association and our members, we'd like to express to you our appreciation for the opportunity to appear before this committee today.

The Ontario Association of Community Care Access Centres is a voluntary organization that represents Ontario's 42 CCACs. As the provincial voice for CCACs, our mission is to support and represent the interests of our members, to provide leadership in shaping health care policy and to promote best practices on behalf of the people served by community care access centres.

CCACs are statutory corporations under the Community Care Access Corporations Act, 2001, and provide services under the Long-Term Care Act, 1994. Under the provisions of the Community Care Access Corporations Act, CCAC board members and executive directors are appointed through the Lieutenant Governor in Council. The centres receive 100% of their operating funds from the Ministry of Health and Long-Term Care, with total annual provincial budgets of approximately \$1.2 billion.

Each year, Ontario's 42 community care access centres provide coordinated access to health and support services to approximately 500,000 clients to assist them to live at home and maximize their independence. In addition to being responsible for in-home care, CCACs also manage approximately 25,000 placements in long-term-care facilities, provide health services to children in schools, provide information about other community services, and refer clients to those services when appropriate. Last year, CCACs arranged 6.5 million nursing visits, 15 million hours of personal support and home-making, and over 1.3 million therapy visits.

The vast majority of CCAC funding is used to provide home care services, with three key objectives: First, hospital substitution to prevent the need for hospital admission or enable people to return home from hospital sooner; second, maintenance to enable people with long-term health care problems and functional disabilities to live as independently as possible in their own homes, and prevent or delay the need for long-term care placement; and third, prevention to promote wellness and avert deterioration of health to higher levels of care, and to support family caregivers.

CCACs interact with all other parts of the health care system: physicians, hospitals, long-term-care facilities, school boards, community service agencies and health service providers. CCACs provide coordinated care through our case management system and have major responsibilities in assisting individuals to navigate the

health care system. CCACs manage over 1,000 contracts with nursing, personal support and therapy service providers for the delivery of services that are responsive to the changing needs of our clients and meet consistent quality standards.

Mr Chair, let me begin my comments by stating our support for the principles outlined in the preamble to the legislation. We strongly support the need to evolve to a full continuum of health care that goes beyond hospitals and physicians, and includes access to primary care, home care and catastrophic drug coverage. We also believe that collaboration between government, health care providers and consumers is essential to the development of a seamless, responsive and sustainable system of health care.

We support the creation of a health quality council to monitor and report on the effectiveness of the health care system in meeting key goals and improving population health. Although we can see the wisdom in creating a council with an expert membership that does not include health care providers, we are hopeful that there will be opportunities for providers to give advice and assistance to the council in the development and measurement of performance indicators.

1230

CCACs are also committed to being accountable to their local communities, their health care partners and the Ontario government for the efficient delivery of high-quality care and the wise and prudent use of public funds. As statutory corporations, CCACs are accountable to the Minister of Health and Long-Term Care through a memorandum of understanding signed by the minister and deputy minister and the board chair and executive director. In addition, CCACs prepare annual business plans and provide detailed monthly, quarterly and annual reports to government on spending and service activities.

This year the OACCAC developed a provincial database using data from CCAC monthly activity and expenditure reports and has begun providing comparative feedback to each CCAC on its own performance in relation to its peer organizations across the province. The board of the OACCAC has established a performance indicators committee to begin to develop meaningful and reliable key performance indicators for CCACs and for interested and concerned government officials, as appropriate.

However, as the minister noted in his comments to this committee last week, accountability is a two-way street. It is important that the accountability relationship between government and health care providers be focused on trust, collaboration, learning and improvement, and not simply on command and control.

In building a system that fosters collaboration and innovative approaches to system integration, we also believe it is important that the accountability relationship between the government and major health care providers be consistent, fair and, above all, workable. To this end, we believe that Bill 8 provides an opportunity for the government to reconsider and amend some of the

accountability provisions of the Community Care Access Corporations Act, 2001, that result in CCACs being treated quite differently, and perhaps inappropriately, from our other health care partners.

Under the CCAC act, CCAC executive directors are appointed through the Lieutenant Governor in Council. CCAC boards are obliged to employ as the executive director the person appointed by the Lieutenant Governor in Council and are obliged to terminate the executive director's employment if the term expires or the appointment is revoked. In addition, the minister, not the board, is responsible for fixing the salary, benefits and other remuneration of the executive director.

Our experience has been that this framework creates a system where accountability relationships are dual, often ambiguous, and board governance responsibilities are diminished. This approach also results in a corresponding increase in government obligations in administering the appointment process which are both unwieldy and place an additional burden on the public system. There is a high degree of uncertainty and instability, as appointments tend to be reconfirmed, without future terms and conditions stated, within days of the expiration of the current term. In fact, this month, 14 senior executives had OIC appointments extended the day they expired. This is no way to build morale.

Within this framework it is difficult to attract new executives from outside our sector. As it is, almost all the executive director vacancies in our system since the proclamation of the CCAC act have been filled by internal candidates. They are highly qualified individuals, but over the long term our sector will be strengthened by an ability to draw upon people with a wide variety of skills and experience.

In reviewing the performance agreements between the British Columbia Ministry of Health Services and health authorities, the BC Auditor General commented on the risks associated with ambiguity in the accountability of chief executive officers, stating: "Traditionally, boards decide on CEO appointments, terminations and remuneration. Again we found it was unclear whether the CEOs are accountable to the boards, the minister, or both. This situation creates a number of personal risks. One is that the boards can be bypassed in strategic decision-making, becoming advisory boards rather than governing boards. Another is that the CEO will receive conflicting messages. A third risk is that the CEO will view his or her job as that of managing the board on behalf of the ministry, rather than reporting to the board."

In his remarks to the committee last Monday, the minister suggested that amendments would be forthcoming that would mandate the creation of accountability agreements between the minister and boards, with a requirement for separate performance agreements between boards and chief executive officers. We believe this is the right approach to promote clear, unambiguous accountability and to enhance board responsibility for governance.

The minister further intimated that direct government intervention in CEO employment and compensation

would only occur in exceptional circumstances where all other recourse has failed. This is at odds with the current provisions of the Community Care Access Corporations Act that give government the ultimate authority for CCAC executive director employment and compensation.

Bill 8 provides for an opportunity to supersede those provisions of the CCAC Act, 2001, that are contrary to the expressed intentions of this government and would greatly improve the policy and working environment as seen by CCAC boards and executive directors. An amendment would strengthen and clarify the accountability model for CCACs, provide greater stability, and provide an intensely satisfying morale booster. The bottom line is that boards cannot be held accountable for that which they don't control.

In conclusion, let me express my appreciation again for the opportunity to appear before this committee and share our experiences.

The Chair: Thank you very much, Mr Libbey. You've used up about 11 minutes. Each party will have three minutes. Ms Martel, you're first.

Ms Martel: Thank you for being here today. I see you're specifically recommending that section 10 be repealed. Section 10 deals with the minister's appointments of executive directors only.

You wouldn't be surprised to hear me as a New Democrat say that I think there are some other provisions that should also be repealed, specifically the provision where the minister appoints the whole board as well, and where the minister controls what kind of information is provided. We opposed Bill 130; I continue to. I think that other health care organizations elect their board under the Corporations Act, and the same thing should apply to CCACs. So I don't want to offend you; that's not my intention, but you need to know where I'm coming from. The government shouldn't just go partway. The government should repeal the bill, because it was clearly used as a mechanism to control CCACs and the flow of information.

So let me ask you this, given that you've talked about executive directors, and I agree: What do you think about going the whole nine yards and dealing with the repeal of the other sections that allow for appointments instead of election of boards and that allow for the minister to control the flow of information rather than having some of that information which is public actually be publicly disclosed again?

Mr Libbey: If I may, we're not asking for that at this point in time. Clearly, we used to operate under that model before Bill 130. My sense is that that's quite an acceptable way to manage health care governance. I think the OACCAC's position is that we need accountability for health, and we'll stand behind that, regardless of how the government chooses to arrange the governance.

Ms Martel: But surely accountability has to do with reflecting the positions and the values and the input from the community, and it's hard to argue that that is happening if the minister, sitting in Toronto, is making

the appointments. I think if you really want to talk about accountability at the community level, that also has to mean having an election, having a general meeting, selling memberships, allowing people to participate and come forward and try to get on the board. Do you agree?

Mr Libbey: I can support your position, but also recognize that the Lieutenant Governor in Council appointments are members of the community, and so they do bring some of those values to the table.

Ms Martel: They do, but forgive me; what I saw happen in our community was that everyone who was appointed essentially ended up having a Conservative membership. I remain unconvinced that that was the best way to proceed. Yes, they might have held different positions in the community, but it was hard to argue that they had been democratically elected on any level.

If we're talking about a bill that talks about medicare and accountability—and there are a lot of sections I disagree with in this bill—I think we should be moving that other step to make sure that your organization, like other health care organizations, has a democratically elected board and an annual meeting and disclosure of information under the Corporations Act.

1240

The Chair: Thank you, Ms Martel.

Mr Heinz Schweinbenz: If I may answer that question also.

The Chair: Very, very briefly.

Mr Schweinbenz: In our particular case, both governments, the previous government and this government, looked to the chair for nominating people who would be acceptable to the government. I know in the ideal world it didn't always happen that way, but in our particular case, in both governments, we did get the people we nominated.

Ms Wynne: I suspect that some of this conversation goes beyond the bounds of Bill 8, so I'd like to ask you a question, because there's been a lot of talk about the silos of health care and the fracturing of health care in our communities.

You make a comment about coordinated access to health care, and certainly that's one of the things that we're interested in. Can you talk about, from your perspective, how that coordination could be better? How could we better coordinate all the services? My understanding from some of the delegations we've heard is that there actually has been a fracturing over the last eight years; it hasn't become more coordinated and the silos haven't broken down. Certainly putting this accountability framework in place is part of what we're trying to do to rein some of that in and make sure that the health care dollars go where they're needed, and in order for that to happen, there has to be coordination. Can you talk about, from your perspective, how things could be better coordinated?

Mr Libbey: A couple of ways. The first is that one of the things that's vested with community care access centres is case management—or care management, if you like. So that particular service that we provide for clients

in the community is a way of connecting or providing the system navigation that I referred to earlier in the report to help those people move seamlessly through the various aspects of health services that they need. That's one of the ways.

The other way is that I think we're starting to find that many of the community care access centres are now starting to look at the more advanced management techniques of balanced scorecarding. By doing that in conjunction with other similar-minded organizations, they start to find that they're talking the same language. Those objectives that come through balanced scorecarding are not just the financial ones, but are the ones that talk about the clients and the quality of care. So those are the kinds of things that are happening.

Ms Wynne: Do you see an opportunity with this framework to possibly have accountability agreements with a number of providers or a number of organizations that would have agreements that would have as their goal improved coordination? Is that even a possibility from your perspective? I'm not sure what balanced scorecarding is.

Mr Libbey: For example, that's one of the objectives that our community care access centre from the eastern counties has put in place, that and improving our dialogue with physicians. Those are the kinds of things—whether you want to put them in an accountability agreement or not is hard to say, but essentially the objectives of system-wide coordination are things that CCACs, just by their general nature and where they are positioned, always want to do and get involved in. So anything you can do to make that easier for us, I think, is better for the client.

Mrs Witmer: Thank you very much, members of the CCAC, for being here today. I just want to make a comment. I would disagree with what Ms Wynne has just said. I think in recent years the government has made a tremendous effort to break down the silos and move toward a continuum of care, starting, obviously, with the provision of services to keep people healthy such as introducing the universal flu vaccine, free to everybody, introducing primary care family health networks, then moving into the hospital sector, then moving into the home care sector, the CCACs and long-term care. Certainly the investments that have been made in long-term care and home care in recent years are far in excess of what we've seen in the rest of Canada. So I think we need to continue, and I hope this government will continue, to move forward in providing that continuum of care.

Your concerns about the appointment of the executive director make me a little bit nervous as to the power that the minister is going to have under this new Bill 8. In some respects, the problems that you've had with your executive director and the lack of accountability that he or she has to you are what the government is envisioning is going to happen by the new CEO of the hospital having this accountability arrangement with the minister. I guess I hear you saying it didn't work, it doesn't work, and yet the government almost seems to be going that

way, where the CEO would have to be accountable to the minister. In some respects, this would mean that the voluntary governance structure in hospitals would no longer have the same relationship with the CEO.

Mr Schweinbenz: To answer that specifically, we're here to see that Bill 8 might be an opportunity to correct a flaw in Bill 130.

Mrs Witmer: Right.

Mr Schweinbenz: The appointment of the executive director, sometimes without consultation with the board as to who their choice is and so on—in Niagara it has taken a long time to fill that vacancy, partly because they couldn't attract the person, but partly because they had no say in the end. So we're seeing Bill 8 as correcting a flaw in some other legislation. And yes, we're an example of what other people have been saying to you.

Mrs Witmer: Yes. And do you know what? I don't disagree with what you're asking for. I think we should give serious consideration to taking a look at making sure that individual is appointed or hired in a different manner, and I would support you in making the board much more responsible and making sure that position is more than just advisory.

The Chair: Thank you for coming today.

We've had a little change in the schedule. Instead of coming back at 2 o'clock, we don't need to be back until 2:20.

The committee recessed from 1248 to 1421.

ONTARIO ASSOCIATION OF MEDICAL LABORATORIES

The Chair: Ladies and gentlemen, if we can come to order again. Our next delegation is from the Ontario Association of Medical Laboratories: Paul Gould, chief executive officer; and Ken Kirsh, board member and executive vice-president of Gamma-Dynacare Medical Laboratories. Come forward and make yourselves comfortable. You get 20 minutes to make your presentation, and you can use that time any way you please. If there's any time left over after the presentation, we would use that time for any questions that members of the committee may have. We do that on a rotational basis. The floor is yours.

Mr Paul Gould: Good afternoon. My name is Paul Gould. I am chief executive officer of the Ontario Association of Medical Laboratories. With me today is Ken Kirsh, a member of our board and co-chief executive officer and executive vice-president of Gamma-Dynacare Medical Laboratories.

I should like to begin by expressing my appreciation to the members of the committee for the opportunity to speak to you today on behalf of the OAML and its members, Ontario's community laboratories. Our member laboratories help serve the diagnostic needs of over 15,000 physicians, practical registered nurses and midwives by performing diagnostic tests on more than 14 million patients annually through our network of more than 400 patient service centres throughout the province. We provide services to residents in over 500 licensed

long-term-care facilities and we provide in-home services coordinated through the community care access centres.

The OAML supports the principles underlying Bill 8 and the government's intent to develop a transparent and accountable health system for Ontario. Our members pay taxes too. We want to know that our taxes are spent in such a manner that we have the best health system for dollars spent in the world. The people of Ontario deserve nothing less.

The OAML is supportive of the creation of a quality council to provide the people of Ontario with an assessment of the performance of the health system as a whole and believes the government has made a wise decision in establishing such a body. We agree with the principles of mutual accountability and transparency within the health system. We as an industry have entered into funding and service agreements with the Ministry of Health for the last decade. Each of these agreements has specified annual amounts that community laboratories will be paid for the delivery of all OHIP-insured laboratory services. Each has also specified certain initiatives that the OAML and the community laboratory sector as a whole must undertake to promote best-use testing, codified service delivery or to participate as an active partner in the laboratory reform process.

More recently, as part of the laboratory reform process, our members have committed to entering into laboratory provider service contracts with the ministry. These contracts reflect much of what is being contemplated in the accountability agreements described in Bill 8. Service expectations, service standards, accessibility of services and reporting requirements are all among the elements contained in these contracts.

Ontario's community laboratories have been at the forefront of the reform of the health system. We have worked with successive Ministers of Health to ensure that the laboratory services available to patients in their own communities are of the highest quality, reliable and accessible. During the SARS outbreaks of 2003, community laboratories demonstrated that we are the surge capacity in the system by providing testing to hospital outpatients when hospitals were forced to close. We were approached by the Ministry of Health to help and we stepped into the breach, no questions asked. Such is the nature of our relationship. We are partners with the Ministry in the delivery of health services.

We support the minister's decision to expand the application of accountability agreements to other designated health resource providers. There are several sections of this bill, however, that are a cause of concern to us. We are pleased that in his address to this committee on February 16, the minister recognized some of our concerns, and we look forward to seeing the specific amendments that will be tabled on March 9. We understand and support the government's need for accountability for health dollars spent, but we are disturbed at the extent to which the bill, as currently drafted, seeks to impose ministry micromanagement of the health system.

We have concerns with the provisions of section 14 respecting the role of the general manager of OHIP with

respect to the information he or she might decide to collect. There is no limitation on the generality of the power delegated to the general manager of OHIP. This is particularly troublesome since this section requires that providers report data on uninsured services that they provide to insured persons to the general manager of OHIP. Community laboratories are licensed to provide services that are not insured by OHIP. It is already a condition of our licensing that we report annually to the ministry the total numbers for each uninsured service that we provide. We view this section as overly intrusive. It allows the general manager of OHIP to access proprietary financial information as well as personal information about health services provided which are not reimbursed by OHIP.

We are concerned at the provisions of section 21 that allow for ministerial imposition of accountability agreements which will be deemed to have been arrived at mutually. Section 24 allows the minister to terminate or vary the terms of any accountability agreement.

We are concerned with the provisions of section 22 respecting compliance directives. These sorts of provisions might be necessary in a state of declared provincial or local emergency, but we are concerned, once again, that there is no limitation on the generality of ministerial power. We are concerned that section 29 of the bill would allow the minister to collect and disclose proprietary financial information.

We will be reviewing the amendments tabled on March 9 to be assured that our concerns are addressed. The minister has declared to this committee that Bill 8 will be subject to the provisions of the Health Information Protection Act, Bill 31. This will impose severe limitations on the ability of the general manager of OHIP to collect personal health information. We have been told that the minister will not be permitted to collect personal health information. We are pleased that the minister recognized the need for changes to these sections and we welcome the promised amendments.

We also welcome amendments that reflect that the ministry does not intend to micromanage the delivery of health services through the imposition of accountability agreements. We appreciate the minister's clarifying comments with respect to responsibilities and accountabilities of CEOs and the boards of directors.

I will conclude by saying that success in addressing the challenges facing our health system today requires mutual accountability and transparency on the part of both providers and government. The accountability framework, however, must be fashioned within a partnering, not an adversarial, paradigm. The minister rightly pointed out that the tone of certain sections of Bill 8 must change. We would suggest that the detailed elements of Bill 8 must also reflect the partnering paradigm.

Thank you for your time this afternoon.

The Chair: Thank you, Mr Gould. You used up about eight minutes, which has left us with 12 minutes. That'll be four minutes for each party, starting with Ms Wynne.

Ms Wynne: I'm hoping that a number of the amendments that come forward will meet your requirements,

sections 21 and 22 in particular. I just wanted to make you aware of what we're proposing.

Under section 21, we're suggesting that the independence of the governance structure would be maintained. So the health resource provider could be required to have a performance agreement with its CEO that's consistent with key performance requirements contained in the accountability agreements. So the accountability agreement would be between the ministry and the board, and the performance agreement would be between the board and the CEO. So that will be clarified.

In section 22, we're going to clarify what the procedure is by which that accountability agreement is put in place. You talk about mutuality and the need for a discussion, and that's exactly what we're proposing. Is that the kind of amendment you're looking for?

1430

Mr Ken Kirsh: Let me just clarify the point about the boards and the CEOs. A lot of the health providers in the province, including our members, are private corporations. So the boards of directors and CEOs often sit in the same shoes, and I don't quite understand how that's going to affect us or why it should affect us. There should be an accountability contract between the corporation directly and the ministry. It really has nothing to do with the CEO. I think that's something from another sector of the health care system that shouldn't affect us and really has no place within private corporations. I'm not sure the amendment deals with that.

Ms Wynne: So, in terms of an accountability agreement, what's the framework, then, you're looking for?

Mr Kirsh: We think the accountability contract should be directly between the ministry and the corporate entity. It has nothing to do with the board or the CEO; that's not the paradigm we live in. The board of a corporation may or they may not fire their CEO over meeting the accountability contract, but that's up to the corporation to decide. It's up to the ministry to decide whether or not it wants to penalize in some way shape or form that corporation for not meeting the accountability. It has nothing to do with the CEO directly.

Ms Wynne: Even in the paradigm that I was talking about, the accountability agreement doesn't have anything to do with the CEO directly. The CEO is not the person who has the accountability relationship with the ministry.

I think one of my colleagues has a question.

Mr Bob Delaney (Mississauga West): I have a question for you on your brief. You state on page 4, "The minister has declared to this committee that Bill 8 will be subject to the provisions of the Health Information and Protection Act.... This will impose severe limitations on the ability of the general manager of OHIP to collect personal health information." On page 3 you say, "There is no limitation on the generality of power delegated to the general manager of OHIP." Could you explain for me this apparent discrepancy?

Mr Gould: I'm making the distinction between the way the bill is currently drafted and the comments of the

minister when he appeared before the committee on the 16th. In his remarks he made reference to the fact that the minister himself would not be able to access personal health information.

Mr Delaney: Thank you for the clarification.

Mrs Witmer: Thank you very much for your presentation. I see that in the case of your association this bill does have some negative implications and that you would ask the minister to address these. You talk about section 14 and the role of the general manager of OHIP. I wonder if you could just explain to the committee why this is so troublesome. I know there is a paragraph here, but maybe you could just give us some examples of what you mean here.

Mr Kirsh: The uninsured services would be the critical issue. We are licensed to perform uninsured services, but they are uninsured. We do submit the total number of services rendered that are uninsured to the ministry so they know what's generally happening. They can do broad-based studies of what kind of testing is going on in the community. But, on the other hand, the proprietary information that's generated for the physicians that order that service, as well as the financial information that goes behind that, is not paid for by OHIP, has nothing to do with OHIP, and those are direct decisions of the ministry not to have OHIP involved in those. There don't appear to be any limitations on the general manager in terms of collecting that information. So there's a disconnect there, a direct disconnect. That's the example.

Mrs Witmer: Why do you think the ministry would have written section 14 in this way to also apply to uninsured services? If I take a look at the amendments proposed thus far, it doesn't seem that the ministry has yet recognized that this is troublesome.

Mr Kirsh: I honestly don't know what they were after. We just think it's a definite overreach, from our perspective.

Mrs Witmer: If there were one section contained within this bill that you find more troublesome than any other, which one would you be most concerned about as it relates to your association?

Mr Gould: I think the access to information outside the health insurance scheme.

Mrs Witmer: So the section 14 that I've just referred to? Are you satisfied, after you've listened to the government, with some of the changes they're saying they're going to be making to sections 21 and 22?

Mr Gould: We're certainly encouraged to hear that the process will be dramatically changed. Until we see the specific amendments, I can't comment further, but it seems to be moving in the right direction.

Mrs Witmer: I guess once the amendments are going to be introduced, if that's the direction we take, do you believe that an association such as yours should have another opportunity to review the bill, as it is amended, before it would proceed any further?

Mr Kirsh: We would always be happy with a second crack, if there was one given, absolutely.

Mrs Witmer: What about the regulations? Do you have concerns about the number of regulations, that obviously we have no idea at the present time what they may or may not look like?

Mr Kirsh: It's always the detail, the devil is in the detail, and it's true, vis-à-vis regulations versus legislation. For sure we would be going over it with a fine-tooth comb and hope to have some method of speaking to the government on that issue.

Ms Martel: Thank you, both of you, for being here today. I want to begin with your laboratory provider service contracts. Are those actually in place now, or are they still being negotiated?

Mr Kirsh: They were negotiated through the laboratory reform process. The board of our association actually agreed to the format and form of those contracts about two years ago. They still have not yet been finalized with the other members of the reform process; that would be the Ontario Hospital Association and the Ontario Medical Association. Our board is on record as approving those contracts.

Ms Martel: What's the government's role, then?

Mr Kirsh: The government's role, I assume, at this point—again, just an assumption—is to get the OMA and OHA to agree to those.

Ms Martel: So they're not a direct signatory themselves?

Mr Kirsh: No, in that case they're not. In fact, the OAML is not either; it's the individual providers. But to be fair to that process, it is wrapping up in the next three or four months. The final regions of Ontario, the last three regions—there were nine regions dealt with in the reform process—are now wrapping up, so I would expect that in the spring those contracts will be signed.

Ms Martel: I'm interested because you said—

Mr Gould: Could I just clarify for a moment, just in case you didn't understand? The final signatories to the contract will be the Ministry of Health and Long-Term Care and the provider directly.

Ms Martel: But are there terms and conditions for the ministry that are outlined as well? Do they have terms and conditions that they have to meet as part of this? Or are they setting out essentially your obligations and responsibilities?

Mr Gould: The ministry will be committing to a level of funding.

Ms Martel: Will that be articulated right in the agreements, the funding level?

Mr Kirsh: No, there may be cross-reference to the funding agreement but not directly within the provider contract that we talked about, the service standards and accessibility.

Ms Martel: OK. So this process has been negotiated, not imposed?

Mr Kirsh: That process was negotiated, yes.

Ms Martel: Right. The reason I ask that is because you said these contracts reflect much of what is being contemplated in the accountability agreements in Bill 8. You would hope that.

Mr Kirsh: We would hope so. I think we're leading the wave of accountability, and when we saw the bill, we had actually hoped to have some method of showing those provider contracts to the government and saying, "Does this meet with your criteria?" It certainly met with the criteria of the ministry itself when we negotiated them, and knowing that accountability was a critical issue down the road a couple of years ago, I believe that's what they were contemplating. Our view is that they are good contracts. We did agree to them, and we would hope other people would go as far as we went, in fact. We think we've gone quite far. Our view of it would be, here it is, it's a shining light of what we think should be there.

Ms Martel: The reason I raise that is because I think if that's a model that can be looked at, it should be, especially if it was one that was negotiated by the parties, not imposed.

The concern I continue to have has to do with the lack of clarity that I think the minister has provided around the sections that Ms Wynne referenced. I think it's important that I read into the record the rest of the piece that she didn't, so that you will understand the concern. I don't know if you got a copy of this February 19 document that the minister provided through the parliamentary assistant to members of the committee. It came because the minister said last week he was going to try to give us some sense of where he was heading with amendments.

Perhaps, if you didn't see it, you would want to take a look at page 2—actually the third page, section 22, is the one I'm most interested in. It says, "Include notice and other due process provisions"—this, by the way, is with respect to the accountability agreements, all right?—"including time frames for notice, to address development of accountability agreements, issuance of compliance directives and orders (eg discussion process, meetings, exchange of documents/information, representations")—and here's the key—"that the minister has to consider before issuing a compliance directive or an order)." So there's nothing in there that suggests to me that these are going to be negotiated—quite the contrary. The same concerns that we've been hearing so far, that the minister can issue orders and compliance directives, still seem to be in place. The only difference seems to be that he can consider a few more facts before he does that. Does that section concern you?

Mr Kirsh: This is the first time we've seen this, but our agreement itself, our accountability contract if you want to call it that, talks about negotiation and binding arbitration. It does not talk about directives.

The Chair: Thank you for coming today. We certainly did appreciate your input.

1440

ONTARIO ASSOCIATION OF OPTOMETRISTS

The Chair: If I can call forward now the Ontario Association of Optometrists, Dr Shirley Ha and Dr

Christopher Nicol. Make yourselves comfortable. You have 20 minutes. You can use that any way you choose. Any time that's left over will be split among the parties.

Dr Shirley Ha: I'd just like to start by thanking everybody. Thank you so much for allowing us the opportunity to present before the standing committee today. My name is Dr Shirley Ha. I'm an optometrist in practice in St Catharines and vice-president of the Ontario Association of Optometrists. With me today is Dr Christopher Nicol, an optometrist in practice in Bolton and a policy consultant with the OAO.

We welcome this chance to provide the members of the committee, and ultimately the Ministry of Health and Long-Term Care, with our input on Bill 8, the Commitment to the Future of Medicare Act, 2003, as it affects the delivery of and payment for professional eye care services for Ontarians.

Optometrists are front-line, primary eye care practitioners who are responsible for most primary eye and vision care in Ontario. More than three million patients visit an optometrist in Ontario annually for services that include comprehensive eye examinations and treatment in the areas of refractive status, oculo-motor status, sensory status and the physical health of the eye. Patient care also includes the diagnosis and management, in co-operation with physicians, of the ocular manifestations of certain systemic disease, including diabetes and hypertension.

The OAO is a voluntary professional organization that represents over 1,000 registered optometrists in every region of Ontario. In addition to providing resources and continuing education to its members, the OAO is committed to raising awareness of optometry and educating the public about the importance of professional eye care.

Let me give you a little bit of history about the funding of eye care services in Ontario. The provincial government, through a funding agreement under OHIP, currently pays for the majority of diagnostic services provided by optometrists to Ontario residents. The OAO is the organization responsible for negotiating the fee schedule with the Ministry of Health and Long-Term Care on behalf of the profession. OHIP funding for the provision of comprehensive eye examinations has not increased in 15 years. During that time, there have been significant advances in technologies and testing to diagnose eye conditions and diseases, the costs of which the profession is subsidizing out of its own pockets.

The fee for service paid to the optometry profession no longer comes close to covering the cost of providing eye care, and the profession is increasingly concerned about the ability to maintain the standards of care set out by the College of Optometrists of Ontario.

Over the past 15 years, the Ontario government's approach to the issue of funding for optometry services has been frustrating, ineffective in meeting the needs of patients and unfair to the profession.

Currently, Ontario optometrists are operating without a signed funding agreement with the provincial government, the most recent of which expired March 31, 2000,

and the optometric fees for OHIP-insured services are unchanged since 1989. The fees for minor assessment, currently frozen at \$19.25, have not for several years covered optometrists' overhead costs. The fees for oculo-visual assessment, currently frozen at \$39.15, do not provide for fair or reasonable compensation for optometrists' professional services once overhead is calculated.

When one considers inflation, optometric fees in Ontario have not only been steadily declining over the past 15 years, they are now the lowest in the country. As the population grows and ages, the demand for optometric services will only increase and it will become more and more difficult for optometrists to put the required investment into new capital equipment to keep them current with the college's rigorous standards. The OAO is not suggesting that standards should be lowered, but it is unfair to penalize Ontario optometrists for ensuring that they meet or exceed patient care criteria. This is not being asked of other health care practitioners.

Optometrists, unlike, for example, chiropractors, cannot bill any portion of their expenses for an insured service to their patients. And unlike physicians and dentists, optometrists are not afforded the protection of provisions in the Canada Health Act which guarantee reasonable compensation for insured services. You may say that optometrists are in a unique bind. They are caught up with physicians and dentists in the Health Care Accessibility Act, without having the protection of the Canada Health Act.

This brings us to a consideration of the bill before you and the provisions made in it with respect to the profession of optometry. The OAO is currently concerned with Bill 8 as it relates to funding issues for optometry. Accordingly, I will begin with the comment on those aspects of Bill 8 that are most important to this profession and found in part II.

Part II, health services accessibility, sections 7 and 9: For optometrists, the present Health Care Accessibility Act is the most draconian of any legislation to ever affect the profession of optometry. For the past 15 years optometrists have been in a virtual state of bondage to the provincial government and forced to accept insufficient payment for services that the public regard as vitally important. Despite years of attempts at negotiation, the amount payable for an optometric insured service has not changed since 1989.

Presently, the amount payable for insured optometric services does not provide fair or reasonable compensation for those services, as the amount payable no longer covers the cost of providing the insured service.

The lack of any fee increase for 15 years has created a crisis situation for optometrists with respect to acquiring and maintaining the specialized instrumentation necessary to provide the appropriate quality and standard of eye care required of optometrists by the College of Optometrists of Ontario.

Under present legislation, the Health Care Accessibility Act, optometrists are explicitly prohibited in the statute from billing in excess of OHIP rates, or what they

call balance-billing, and receive a fixed payment for any and all services defined as insured services by OHIP. Optometrists, like physicians and dentists, cannot balance-bill or charge a patient more than the amount payable established by regulation. Physicians, unlike optometrists, have had periodic increases in amounts payable for insured services since 1989. Very few dentists receive payments from OHIP. Non-designated practitioners like chiropractors and physiotherapists can balance-bill and are able to offset rising practice costs with private fees.

This inability for optometrists to balance-bill has prevented optometrists from maintaining a sufficient income to adequately cover practice costs.

With the proposed changes under Bill 8, optometrists will no longer be specifically designated as practitioners that cannot balance-bill. The proposed changes in sections 7 and 9 of Bill 8 will provide an opportunity to permit the designation of optometrists as non-designated practitioners for the purposes of accepting payment.

The OAO supports sections 7 and 9 of the bill. Furthermore, the OAO recommends that once Bill 8 becomes law, an optometrist will assume the definition of non-designated practitioner for the purposes of the act, at least until such time as outstanding funding issues have been resolved to the mutual satisfaction of all parties.

Section 10: While this section states that the minister may enter into fee negotiation agreements with associations for determining amounts payable under OHIP, there is nothing in this section that compels a negotiated agreement or provides for recourse if negotiations break down. Consequently, health care practitioners, like optometrists, may never obtain an increase in the amount payable for an insured service, despite increases in cost of living and practice expenses.

The OAO recommends that section 10 be amended to permit some form of recourse, like compulsory arbitration, should fee negotiations fail to result in an agreement.

Sections 11 and 12: Subsections in this part permit the general manager to recover monies from an optometrist without the benefit of a hearing under the Statutory Powers Procedure Act, the SPPA. The OAO opposes any requirement to repay unauthorized payments and to pay administrative charges without the ability to request a review under the SPPA.

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Section 14: This section provides authority to the general manager to require any person or entity that renders an uninsured service to an insured person—this is virtually everyone in Ontario—to submit any information to the general manager. The requirement to disclose information on uninsured services seems unreasonable in legislation that deals specifically with insured services. Furthermore, failing to comply with a request for information on an uninsured service is subject to a suspension of payments for insured services under the plan. Health care professionals should continue to have autonomy over the establishment and application of fees and

charges for services that are in the public domain and not designated as insured services. Additionally, “uninsured services” is not defined for the purposes of this part and could mean anything that the minister decides. The OAO recommends that any requirement for the disclosure of information be limited to information related to insured services. This section should be completely removed from the bill.

Section 15: The prohibitions contained in subsections (1)(a), (b) and (c) are not matters of patient health and safety and should not be subject to mandatory reporting requirements. The OAO suggests that mandatory reporting requirements in this section are unnecessary and should be removed.

Section 16: The definition of a block fee could include uninsured services that optometrists routinely provide to their patients. Contact lens fitting fees and fees for orthoptics or vision training procedures are global fees that are set fees, regardless of how many services are provided. Presently, the College of Optometrists of Ontario regulates fees and charges through professional misconduct regulations specific to the practice of optometry. Uninsured services are not subject to prohibited fixed-fee regulation. Furthermore, the possible penalty of imprisonment for charging a block fee seems excessive, considering the offence. The OAO recommends that for optometrists any regulation of block fees should remain within the authority of the College of Optometrists of Ontario.

Going back to part I, the Ontario Health Quality Council, the OAO supports the establishment of a health quality council. The minister should have timely access to information on the availability of health care resources in order to make informed decisions. Once established, the council could commission appropriate research on public eye care needs amid health human resources in the eye care professions.

Part III, accountability: While accountability is an essential component in the delivery of health care, for optometrists and other regulated health care professionals, accountability is the responsibility of the profession’s regulatory authority. Optometrists are accountable to the public through registration with the College of Optometrists of Ontario.

A “health resource provider” is defined as “any corporation, agency or entity that provides directly or indirectly, in whole or in part, provincially funded health resources.” This definition does not appear to include optometrists; however, the inclusion of “entity” and “any other prescribed person” in the definition of “health resource provider” could be interpreted to apply to a non-individual like an optometric practice or clinic or partnership. The OAO recommends that accountability agreements under this part should not apply to optometrists, either as individual practitioners or as group practice under a clinic designation. The relevant sections should be amended to clearly identify the intended parties.

Part IV, amendments to Health Insurance Act, section 40(2.1): This section gives authority to the minister to

arbitrarily and unilaterally amend a schedule of fees in any manner considered by the minister as appropriate. The order could remain in effect for 12 months. While this authority is contained in present regulatory powers, the authority to unilaterally change a negotiated fee seems unfair. The OAO recommends a change to this section to permit an order to amend a schedule of fees for an amount not less than the amount established by either agreement or negotiation.

In conclusion, the OAO has offered nine recommendations for your consideration. Most important, we believe that the introduction of this bill allows the government to change the basis upon which it funds the services of optometrists, which would allow the immediate redress of a 15-year funding freeze. Thank you.

The Chair: Thank you, Dr Ha. We’ve got just over four minutes left, so I’m going to turn it over to Ms Witmer. Would you use up that four minutes?

Mrs Witmer: Thank you very much for your presentation. It looks to me like, in some respects, the lack of clarity in this bill doesn’t reassure you that you’re going to be covered, and yet in some respects, if you are going to be covered in certain sections, that’s a cause for concern as well.

Block fees: Is this a big issue for you, the fact that that responsibility for the regulation could well be taken away from the college and given to the minister?

Dr Christopher Nicol: It’s not a problem right now, although we do have regulations in the professional misconduct regulations at the College of Optometrists. We normally and usually provide services that would be considered to be block fees under this legislation. However, it leaves itself open to recognition of that; perhaps not a control of that, but at least of having the ministry identify that. We are concerned that there may be controls over that.

Mrs Witmer: How do you see this bill allowing for an immediate redress of this 15-year funding freeze?

Dr Nicol: Right now we are designated in the Health Care Accessibility Act as a practitioner that must only bill OHIP and receive the amount payable. Under Bill 8, that designation will be by regulation, so it will be out of the statute. If we are then by regulation not defined as a designated practitioner, we will be able to balance-bill. That would allow us, at least in the interim, to bill something in addition to the minimum amount that we receive now.

Mrs Witmer: However, not having seen the regulations, you’re not quite sure how they’re going to read.

Dr Nicol: That’s correct. We would hope that this committee would recommend that in the regulations we be defined as non-designated practitioners.

Mrs Witmer: Thank you very much. I see that we haven’t made much progress since 2001.

The Chair: We still have about two minutes left. Ms Martel?

Ms Martel: Can I ask you a question about how, right now, if you have a concern about having to repay money—I gather there’s a provision for you under the

Statutory Powers Procedure Act. Is that an appeal mechanism? Can you explain that to me?

Dr Nicol: I'm not a lawyer—

Ms Martel: Neither am I.

Dr Nicol: —and I'm not totally aware of that, but it wasn't in the previous legislation. It's being introduced now. It appears, as I read it, that it will remove the ability of a practitioner to have due process in that it would allow for repayment without a review under the Statutory Powers Procedure Act.

Ms Martel: Tell me, what do you have in place right now yourselves, as an association? What is your recourse at this point if the general manager wants to recover monies? The fee schedule is in place; I don't know how you could possibly get around it. But what is the mechanism right now if the general manager would say to you that he feels there are billings that are inappropriate? What is your appeal mechanism now?

Dr Nicol: I understand that there is a review by the Optometry Review Committee that was established under the Health Insurance Act and then there is an appeal mechanism if the application of that review finds that a member has billed inappropriately.

Ms Martel: Is the Ministry of Health a party to that? Is the Optometry Review Committee outside of your own college?

Dr Nicol: That's a committee of the college.

Ms Martel: Let me ask a question about coverage, because I didn't understand this very clearly. I apologize. This is on your page 4, near the bottom, your second sentence: "And unlike physicians and dentists, optometrists are not afforded the protection of provisions in the Canada Health Act, which guarantee reasonable compensation for insured services."

Dr Nicol: As I understand, in the Canada Health Act there is a requirement that physicians and dentists receive adequate remuneration, and optometrists are not included there.

Ms Martel: Not listed in some way?

Dr Nicol: That's right.

Ms Martel: I'm sorry, I don't—

Dr Nicol: In the Canada Health Act.

Ms Martel: OK. I think that's it.

The Chair: Thank you, Dr Nicol and Dr Ha. Thanks for coming today. We appreciate it.

Ms Wynne: Mr Chair, I know that the time was used up, but I just wanted to clarify something because I didn't want people to leave with the wrong impression.

The Chair: OK, very briefly.

Ms Wynne: Yes, very briefly. As I understand it, you're assuming that this bill allows you the designation of non-designated practitioner. Is that right? As I read it, as I understand it, it may open the door for you to ask for that, but it isn't automatic.

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Dr Nicol: That's right. Under the present legislation, we are specifically identified and under this bill we wouldn't be. Therefore, by regulation we could be defined as a non-designated practitioner.

Ms Wynne: Right, but that would have to be another step. As I read your brief, I was worried that you thought that you would be automatically.

The Chair: I think we're all on the same page now.

Dr Nicol: Again, we would hope that the committee would recommend that.

Ms Wynne: It's absolutely your right to say that.

The Chair: Thank you for coming today.

COMPREHENSIVE REHABILITATION AND MENTAL HEALTH SERVICES

The Chair: Our delegation who was scheduled for 3:20 has been kind enough to move up to the 3:00 slot. That is COTA, Comprehensive Rehabilitation and Mental Health Services, Sandra Hanmer, who is the president and CEO.

Welcome. Make yourself comfortable. You've got 20 minutes to use as you see fit. Any time that is left over will be split amongst the three parties for any questions.

Ms Sandra Hanmer: OK, great. I'll just wait a moment as my brief is going around, if that's all right.

The Chair: No problem. Any time you're ready.

Ms Hanmer: Good afternoon, Mr Flynn and fellow committee members. As introduced, I am Sandra Hanmer and I'm the president of COTA, Comprehensive Rehabilitation and Mental Health Services. Unfortunately, my colleague Mark Schroeter is ill today and not able to accompany me. I am, however, pleased to have the opportunity to provide you with our thoughts and ideas on Bill 8. Our intention today is to provide you with a brief background of our organization and share the unique perspective of a leading community-based provider on this proposed legislation.

COTA is a not-for-profit, accredited community health and social services organization. Established in 1973, we are a proven leader in providing comprehensive rehabilitation, mental health, and support services to people of all ages throughout the province of Ontario. Last year, we delivered client-centred care to over 21,000 individuals, enabling them to achieve greater independence by remaining in the community setting. While most of our programs are based in the greater Toronto area, we have recently extended our scope of service to London and Ottawa. This makes us one of the largest direct providers of community-based health care services in the province.

COTA interacts with all other parts of the health care system. Our rehabilitation services are delivered through our contracted partnerships with nine community care access centres across Ontario. The CCAC system represents 4.2% of Ontario's \$28-billion health care budget. We also provide services to society's hardest to serve, such as those living with mental illness. COTA delivers site support, court support, hostel outreach, case management and aftercare programs that are all funded either through the Ministries of Health and Long-Term Care, Community and Social Services, or Children's Services. These transfer payments to organizations such as ours

represent an additional 1% of the provincial health care budget.

We are pleased to see the government recognize that in order for our health system to remain relevant and function as a system, it must encompass a full continuum of care, including home care and community services. National research studies continue to provide evidence that home and community care is a cost-effective alternative to hospitals, nursing homes and emergency rooms. Yes, we must keep our hospitals functioning to provide important acute care services, but we also require appropriate public policy and sufficient funding to support home and community care services. They play a critical role in assisting patients discharged from hospital and reducing readmission rates.

COTA supports a public policy that provides Ontarians with the right services at the right time. Our current health care system operates in silos, and we need to change that. Nowadays, there are many places other than hospitals where people receive health care: in homes, community organizations, workplaces, schools, and local clinics. An ideal system would deliver value for money by encouraging innovative local health care initiatives that create a seamless continuum of care for people living in local catchment areas.

Relatively speaking, COTA provides value for dollars by helping clients stay in the community longer and avoid more costly stays in hospitals and other institutions. Studies have shown that the average cost of one day of care in a hospital is \$812, \$117 for a nursing home, yet only \$44 for home care. Evidence-based research has also demonstrated that when services such as community mental health, for example, are funded adequately, hospital visits can be reduced by up to 80% for that particular population.

COTA welcomes the government's support for an integrated, consumer-centred health system that ensures access is based on need and not on an individual's ability to pay. We strongly support the overarching principles and key provisions of the bill, including establishing the health quality council, embracing the five principles of the Canada Health Act, and adding accountability as a sixth principle.

I would now like to share our viewpoints on Bill 8 as it pertains to entrenching accountability, strengthening prohibition of two-tier medicine and establishing a provincial health council.

COTA supports the government's intent to strengthen the principle of accountability within our health care system. However, Bill 8 appears to be largely one-sided. It focuses on how to make health care providers more accountable to government, yet does not provide similar details on how the government will meet its obligations of ensuring the provision of health care. We feel that the accountability provisions of Bill 8 do not sufficiently recognize the interdependent nature of the relationships between all key players within the health care system and the government. We are, however, encouraged by the minister's recent admission that accountability is a

collective responsibility that the government is prepared to share.

COTA already is a leader in accountability within the community health sector. We are committed to improving service delivery through ongoing research and quality improvements. We have invested in new technology to integrate our information management systems more efficiently, and we continue to build effective partnerships with other organizations—like the CCACs, the Ministry of Health and Long-Term Care, the Centre for Addiction and Mental Health, school boards and others—to develop health care solutions that are integrated, measurable and cost-effective.

We demonstrate accountability through our own performance. Last year, we were accredited for the second time by the Canadian Council on Health Services Accreditation. COTA was one of the first community-based organizations to receive CCHSA accreditation, reflecting our ongoing commitment to best practices and quality improvement in our service delivery. These performance indicators are also a measure of how we can share, in the community sector, standards that the government is looking for.

The government believes that the future strength of Ontario's health care system depends on all key players sharing responsibility and working together. However, the current provisions do not provide for shared accountability, and in fact appear at the moment to reduce the government's legislative accountability. Bill 8 must provide for more government accountability.

For example, there is no reference in Bill 8 to the minister acting in the public interest when implementing performance agreements. Yet it allows the minister to order fundamental changes in the health care system and issue compliance orders with little, if any, public consultation, procedural safeguards, transparency or other checks and balances. This is inconsistent with the commitment to a shared approach to accountability, as outlined in the November throne speech. We propose that if the government is serious about supporting the key tenets of medicare, this legislation needs to provide clear definitions of "accessibility," "universality," "quality" and "medically necessary." For a point of clarification, COTA also requests elaboration on the definition of "rehabilitation." It's our understanding that this includes case management but does not automatically apply to our rehab health care practitioners in the community.

We believe the health system should be accountable to the people of the province and not just the minister. An accountable health system must include diverse board representation governing health care sectors; full public reporting on health care finances; whistle-blower protection; public consultation and debate about changes to the health care system; and finally, stable, multi-year funding for all aspects of the health care system.

This last point is particularly relevant for COTA and other community-based organizations. Currently, there is no mention of the ministry's overarching duty to fund the system adequately, as set out in the Canada Health Act.

While Bill 8 purports to enshrine the accessibility criteria under the health care act, the government makes no reference to providing stable, multi-year funding for health organizations. For the last several years, funding for the community health sector has not been stable, nor adequate, and certainly not predictable. For example, reductions to funding for assistive devices have left many unable to access the tools they need to live independently. Inadequate home care budgets have led to harmful cuts in service and instability within the community sector.

This situation could become more critical if, for example, hospitals are required to meet specific service level targets in their performance agreements. Many of the clients we now serve have been recently discharged from hospital. If there are unexpected increases or decreases in visit volumes, organizations such as ours may not have sufficient resources to recruit and retain qualified health professionals to meet the demand.

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Furthermore, home care budgets may not be sufficient to sustain the service increases. COTA recently experienced the aftershocks of CCAC cost containment strategies and knows only too well the challenges that visit volume fluctuations can pose. We therefore urge the government to revise the legislation to address the sustainability of the community support sector through stable multi-year funding.

We also request clarification on how this proposed legislation impacts governance. As a contracted partner with various CCACs, we expect our service agreements to reflect the accountability agreements the CCACs and the Ministry of Health and Long-Term Care will enter into. However, as mentioned earlier, we are also a transfer payment program. Will COTA be expected to enter similar accountability agreements directly with the ministry? If so, we feel this would seriously undermine the role of our board and be detrimental to good governance in our area. We therefore ask the government to clarify how this bill might impact community-based transfer payment programs.

We are encouraged by the minister's recent comments that Bill 8 is subject to the privacy protections in Bill 31. Currently, Bill 8 contains a number of provisions that permit the minister to collect, use and disclose personal information. This is a breach of privacy rights in Ontario and we recommend its immediate withdrawal.

COTA has some concerns around the current wording of Bill 8 to prohibit two-tiered medicine. This may prevent organizations from developing innovative and value-added solutions to address existing gaps in service delivery and create a more aligned and efficient health care system.

Again, for example, COTA currently receives transfer payment funding to deliver a mental health aftercare program and a geriatric mental health aftercare program. Both programs have been in existence since the mid-1970s and address an unmet need in our community. Our preventive services successfully target a non-acute client

population no longer eligible under the existing visit cap set by the community care access centres.

The transfer payment dollars are not sufficient to cover the full costs of these programs, so, as an organization, COTA supplements the payment to our health care practitioners—the therapists. Individuals utilizing these services are not charged extra, but the health care practitioner does receive more money than what is available in the transfer payment funding. You might say that one solution would be to cap the number of people we serve and create waiting lists. However, I'm not convinced that's the intent of the proposed legislation. If the government is serious about recognizing home care as an essential part of our health care system, it needs to reconsider putting such legislative barriers in place that prevent future improvements to the system.

COTA supports the creation of a health quality council for Ontario and believes that it could play an integral part in enhancing the accessibility and accountability of our health care system. However, COTA is concerned with the proposed membership of this body. By prohibiting key players within the health care system from participating, the council may be denied critical knowledge and expertise required to understand the complexity of health care issues facing Ontarians. We would like to see this council comprised of all key players in the health care system such as patients, advocates and health care providers, obviously including the overlooked community and health care support sector.

We do not agree, as the minister has recently stated, that such a council membership would advance individual stakeholder agendas. Instead, we feel it would reinforce and support the government's position that our health care system is the whole of its complementary parts. COTA has over 30 years' experience delivering community-based health care and evaluating outcomes of our services. Organizations like ours could therefore offer a unique and necessary perspective to propose innovative solutions to improving and monitoring our health care system.

COTA would prefer to see the proposed role of the council strengthened. Currently, the council may make recommendations to the minister, but only in regard to future areas of reporting. We believe the council could be more effective by amending provisions in Bill 8 which narrowly limit its function and reporting powers. We propose that the council investigate how well the health care system conforms to the principles of the Canada Health Act. It should conduct its operations in a completely transparent manner and make recommendations to hold the government accountable.

In conclusion, COTA fundamentally endorses the intent of Bill 8 to enhance accessibility and promote accountability within the health care system. However, we take issue with the way in which these proposed changes place a disproportionate share of accountability on health care practitioners and limit their involvement in the health quality council. We propose that Bill 8 be amended to ensure that both providers and government

are held accountable to Ontarians for the health care they receive. We welcome and support the minister's suggestion of a 60-day consultation period on regulations.

Ontario is well positioned to introduce new ideas and models for health care whereby primary care, institutional care and community care all work together in a fully integrated, cost-effective health care system. We look forward to working collaboratively to begin repositioning our health care system for the future.

Thank you for your time today.

The Chair: Thank you, Ms Hanmer. We appreciate it. You've used up about 15 minutes, so why don't we start this time with Ms Wynne.

Ms Wynne: I just have a couple of quick comments and then my colleague Ms Mitchell has a question. Thank you for your presentation. On page 4 of your presentation, you talk about the public interest. One of the amendments that's being suggested is that public interest be put into the preamble of the bill so that it becomes one of the underpinnings. Would that go—

Ms Hanmer: Perfect. That would be great. Just the flavour of the tenets of "in the best public interest" was missing from the legislation, as we read it.

Ms Wynne: You talk about compliance orders and so on. Section 22 is going to be amended, and the general direction we're going is on more transparency and more clarity and what that process is going to be in terms of developing the accountability agreements and what the steps would be leading up to the issuance of a compliance directive or an order. So that's our attempt. A copy of the outline of the amendments is over on the other table if you want to take a look at it.

Ms Hanmer: That's great.

Ms Wynne: I'm going to let Ms Mitchell ask her question so we don't run out of time.

Mrs Carol Mitchell (Huron-Bruce): Thank you very much for the presentation. I have a very quick question, and it's on one of your comments: "If the government is serious about recognizing home care as an essential part of our health care system, it needs to reconsider putting such legislative barriers...." I would ask for further explanation of what you consider legislative barriers. It says, "... in place that prevent future improvements...."

Ms Hanmer: One theme, as we were reading through the legislation, was the inability to continue providing solutions that we are currently providing by using some government dollars to provide a service and partnering with other parts of the health care sector to provide resources that aren't currently funded. The confusion seems to stem from where our practitioners, who are all therapists, fall in the definitions of what's covered by the legislation and what's not. They are self-employed, contracted with us, and we provide them through monies we receive through the CCACs or through our transfer payment programs, or direct private-pay opportunities that exist. There's some confusion in whether we're going to be able to do that kind of partnering in the future, with the legislation. Does that help?

Mrs Mitchell: It helps.

Ms Wynne: Do I have another sec?

The Chair: You've still got about a minute.

Ms Wynne: My understanding under this legislation is that the accountability agreement would be with the CCAC.

Ms Hanmer: This is part of our confusion. We have contracts with the CCAC, and we understand they will have accountability agreements. We also, as a transfer payment program, have service agreements currently with the Ministry of Health, with the Ministry of Community and Social Services and with Children's Services. It's confusing where those service agreements are going to fall and how we'll be held accountable with those.

Ms Wynne: So we need to clarify that, but as it stands now it would be with the CCAC and you would be delivering to them under their accountability agreement.

Ms Hanmer: Under their accountability agreement. That's correct.

The Chair: Thank you very much for coming today. We certainly appreciate it.

I'm not sure if our next delegation is here yet. If not, if you had a brief question of this delegation, Ms Witmer or Ms Martel, I'd entertain it.

Mrs Witmer: Thank you very much, Sandra. It's good to see you here. If I take a look at your presentation, it's obvious that you've not had an opportunity to become involved in any personal dialogue or consultation with ministry staff on this bill.

Ms Hanmer: Not yet, no.

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Mrs Witmer: Because you still appear to have some questions that probably could be answered if that dialogue did to take place.

I guess as I look at it, your emphasis, the area that gives you the most concern, is the whole issue of accountability and the need for not only the providers but also the government to be held accountable. If you've listened to the other presentations, that certainly is a huge bone of contention and concern, particularly because this bill is stressing this need for accountability, this need for almost a sixth principle to the health care system. There was a suggestion made this morning that part III, which is the accountability section, really should be entirely rewritten. It's so badly flawed that it would be impossible to make amendments with what's there. What would your preference be? Would you prefer that it would be totally rewritten based on the information we've received from the stakeholders?

Ms Hanmer: I would agree with the comments you're making regarding the accountability section being probably the most problematic for providers. We certainly would support rewriting that section, based on the feedback that you have, and making sure that you're utilizing the expertise of individuals that you've heard from with respect to outcomes, performance indicators, those kinds of things. There's already a lot of work that has been done that I think could parachute it much further. But it would be very problematic trying to work

with what's there or putting it into regulation at this point.

Mrs Witmer: Thank you very much. I guess that's what we've heard. In the case of hospitals, there are performance agreements that are being worked on and we've certainly heard that from some of the other stakeholders. Thank you very much.

Mr Ernie Hardeman (Oxford): Just very quickly, we've heard a lot, as we just did in the exchange with Ms Witmer, about the accountability part of this. I've been listening to the presentations and have come to realize—on page 5 of your presentation, the first line: "We believe the health system should be accountable to the people of the province and not the minister." It seems that all our accountability that's built into Bill 8 reflects on how we're going to make the providers of the service, the providers of our health care, responsible to the minister, who can then direct the activity of the providers in a way that he or she believes is most appropriate. None of it seems to deal with being accountable to the people we should be accountable to: the people who are using the system. I commend you for that line in the presentation, because as we've heard today in the concern expressed about the accountability in the act, the providers seem concerned that they're putting too many guidelines in place, too many restrictions on how we provide the service, but no one really seems to be talking about being accountable to the people who need the service. So thank you very much for that part of the presentation.

Ms Martel: On your page 5, the start of the second paragraph, you said, "Currently, there is no mention of the ministry's overarching duty to fund the system adequately as set out in the Canada Health Act." I wanted to focus in on that, because the preamble is great. Who could not support this preamble, really? But there's a big gap between the preamble and community agencies on the ground, in particular, receiving funding to deliver some of those very important services that are listed. What do you think you need to see in Bill 8 that would give some legitimacy to accountability by pointing out what the government is responsible for and how the government has to be accountable for the provision of health care services?

Ms Hanmer: Thank you for your question. The key things that we have talked about from a sustainability and accountability standpoint deal with planning and the ability to have the resources—ie funding—to make our plans for year over year. When we've only got funding based on a yearly allocation it's very difficult to make sure that our services that are needed are available. Because we contract with the community care access centres and don't always control or have an idea of what their budgets are going to be, if there is a budget shortfall, for example, then all of a sudden services are cut, which makes it very difficult to keep providers, which makes it very difficult to service the clients, and you're making tough ethical decisions around who's receiving service and who's not. So, multi-year funding, for sure, would be a good piece to be able to incorporate. I recognize it's difficult to do, but I think we need to look

at the mechanisms of how we can go beyond just one-year planning for finances.

The Chair: Thank you, Ms Martel. Why don't we all have a little break, five or 10 minutes, and grab a coffee until our next delegation gets here. You can join us if you like.

Ms Hanmer: Thank you.

The Chair: Thank you very much for coming today.

The committee recessed from 1525 to 1538.

REGISTERED PRACTICAL NURSES ASSOCIATION OF ONTARIO

The Chair: If we can call back to order, ladies and gentlemen, I'd appreciate it. We're actually still a little bit ahead of ourselves here, but our 3:40 delegation is here from the Registered Practical Nurses Association of Ontario. Joanne Young Evans is the executive director and Gabrielle Bridle is the president, if they would like to come forward and take a seat at the end of the table.

Make yourselves comfortable. I don't know if we have any clean glasses down there or not; if not, maybe we could get you some. Are there? Are they clean?

Ms Joanne Young Evans: We'll be good health professionals and—there we go. Thanks.

The Chair: It depends how thirsty you are.

You have 20 minutes. You can use that 20 minutes any way you like. At the end of your presentation, if there is any time left over, we'd like to use that time to ask you some questions, and that will be on a rotational basis among the three parties.

I've got exactly 3:40, and the floor is yours.

Ms Young Evans: Thank you very much. My name is Joanne Young Evans and I am the executive director of the Registered Practical Nurses Association of Ontario, which is also known by its acronym, RPNAO. With me today is the president of our association, Gabrielle Bridle. Gabrielle is also the president of the Canadian Practical Nurses Association and is a practising RPN.

It is a pleasure to speak with you today and to offer the advice and recommendations of our association that we believe will greatly improve Bill 8, the Commitment to the Future of Medicare Act, 2003.

The Registered Practical Nurses Association of Ontario is a voluntary professional association that has represented registered practical nurses, RPNs, in the province since 1958. Our association represents nearly 5,000, or 14%, of the 32,000 RPNs registered to practise by the College of Nurses of Ontario. Our members work in a variety of settings, including acute care facilities, long-term-care facilities, community health, occupational health, and a plethora of other venues such as physicians' offices and educational institutions.

Let me begin by saying that RPNAO supports the intent behind Bill 8. We believe that Ontarians deserve a universally accessible, publicly funded health care system based on the principles of accountability, transparency and accessibility. We do not believe that this bill, as it is currently written, achieves these principles.

Let me say, however, that we are very encouraged to hear that the Minister of Health and Long-Term Care will be tabling amendments with the committee in early March that will hopefully address our deep concerns with parts of Bill 8. We look forward to reviewing those amendments when they are made available.

Bill 8, as you know, touches on a number of areas. First, it establishes the Ontario Health Quality Council. The mandate of this council will be to measure the effectiveness of the health care system in Ontario. The council is designed to ensure accountability in our health care system, to ensure that money is being spent where it should and to ensure that the greatly needed improvements in the system will be made. The RPNAO looks forward to the council's implementation and we look forward to working with it in order to achieve the desired results of improving Ontario's health care system.

Bill 8 also addresses the issue of prohibiting two-tier health care. In principle, we support this part of the bill as well. However, we do have a major concern with sections 13, 14 and 29, relating to the collection, use and disclosure of personal health information. We believe that every attempt by the government should be made to define by statute, not by regulation or otherwise, how personal health information is collected, used and disclosed. To avoid confusion and to reduce costs of implementation and enforcement, we think there must be a single piece of legislation for the protection of personal health information in Ontario.

The RPNAO supports Bill 31, the Health Information Protection Act, which is currently before another committee. We believe that Bill 31 should have primacy, not only over Bill 8 but also across all provincial legislation concerning the collection, use and disclosure of personal health information. We are pleased that the Minister of Health respects this position as well, and we understand that he will be tabling amendments to these sections of the bill to achieve these objectives.

Part III of the bill deals with accountability in our health care system. It also happens to be the source of great anxiety amongst many health professionals and the organizations that represent them, such as ours. Let me be clear: Our concern is not over the principle of accountability per se, but rather with the draconian and one-sided approach the bill has taken. In fact, one of the principles that guides the RPNAO and one that our members strive for, is the principal of accountability.

Does Ontario's health care system need to be more accountable and transparent? Absolutely. Does Bill 8 achieve accountability and transparency? Absolutely not. In fact, if Bill 8 is passed as it is currently written, it will have accomplished nothing more than the drawing of the battle lines between the provincial government and health care organizations and service providers. Obviously, we do not believe this was the intent.

To be frank, part III has gone too far. It has given extraordinary powers to the minister to direct an organization to fire, demote or otherwise sanction any person in an organization without the right of recourse; in the

words of the bill, "change in a person's terms of employment, including a reduction or variation of the compensation payable to, or benefits provided to a person"—subsection 27(1).

Part III allows the minister to direct any individual, organization or entity to enter into an accountability agreement or issue compliance directives. It also allows the minister to terminate or vary the accountability agreement for any reason whatsoever as he or she sees fit and at any time of his or her choosing.

The bill goes further by stating that any accountability agreement entered into by one person automatically applies to that person's successor, regardless of whether the successor has any knowledge of this agreement or was involved in its negotiation.

Part III will also allow the minister to vary private employment contracts retroactively. Further, it specifies that any changes or variations in an individual's private employment contract ordered by the minister are "deemed to have been mutually agreed upon between" the individual and the employer. As well, the change does not entitle the person to any sort of payment or compensation, despite any provision to the contrary in labour law, collective agreements or in his or her personal contract or agreement of employment.

Ms Gabrielle Bridle: As currently written, Bill 8 completely ignores the Employment Standards Act and labour laws in general, as well as any collective agreements and individual employment agreements. The RPNAO is of the strong belief that the government has been overzealous in its desire to create an accountable and transparent health care system in the province by the draconian and heavy-handed approach that the ministry has taken through the provisions outlined in part III of Bill 8.

Having said that, we understand that the Minister of Health and Long-Term Care will be presenting for the consideration of this committee a number of amendments that are to address many of these issues that we have mentioned to you today, particularly with respect to part III. We look forward to reviewing these amendments with the expectation that they will greatly improve this bill.

Transparency and accountability are crucial to the success of our health care system. As we have said, the RPNAO is supportive of the concept of accountability and the overall intent of Bill 8. What we cannot support are some of the measures and the approaches this bill proposes in order to achieve accountability.

We are concerned that the elements of this bill will simply polarize the government and health service providers in this province, which would be beneficial to no one.

The initial steps the government has already taken by its willingness to listen, to take advice, and its flexibility to change have been encouraging to us. As always, we appreciate being included in these discussions to provide our input.

Those conclude our formal comments. Thank you for your attention. We will take questions.

The Chair: That's wonderful. Thank you very much. You only used up about eight minutes, which leaves us with 12. We will give four minutes to each one of the parties. We will go back to the rotation we were on before, and that would be starting with Ms Martel.

Ms Martel: Thank you, both of you, for being here today. I appreciate it. I appreciate the focus on part III of the bill as well. We've heard from many parties, many sides, that this is a rather draconian bit of business and far beyond the current provisions the minister would now have under the Public Hospitals Act, for example, to use the public interest to have a supervisor—this goes far beyond it. No one seems to really know why the government and this particular minister think they have to go to these lengths to deal with whatever issue it is that he wants to deal with.

You may know that last Thursday the minister, through his parliamentary assistant, gave us a copy of some of the areas that he proposes for change. Those are being made available over here, so before you leave, please do grab the February 19 memo. It's addressed to the chair, Kevin Flynn.

I want you to take a specific look at some of the proposed changes around sections 21, 22 and 23, some of the ones you've highlighted. I'll ask you to do that because my concern is that there has been very little change in terms of what is in the bill now and what the minister proposes by way of amendment. For example, although many groups have said an accountability agreement is one that has to be negotiated, it cannot be imposed by the minister; in fact, the changes in section 22 still allow for the minister to issue compliance directives or orders, regardless of whatever the negotiation has produced or failed to produce.

Also, it's very clear in section 23 that the minister still is allowed to change, for example, benefits, wages and salaries of the CEO. There is provision for a compensation clawback or other financial remedies that have yet to be defined.

Please do take copies of those, because my concern is that the government really hasn't heard the concerns that were raised repeatedly as we've gone through this process, and we are in the same position where the minister is essentially in the position of, at any point in time, bringing forward compliance directives or orders that would have a dramatic impact on hospital boards, on workers, on CEOs etc.

You might look for one other thing, and maybe you can comment on this now. I appreciate that it doesn't impact your workers in the same way that it might with respect to CUPE workers, for example, but let ask you this question as well. I think the compliance directives could also have the impact of doing around-the-door changes that would also impact on people's employment. For example, if through a compliance directive the minister ordered amalgamation of cleaning services or contracting out of cleaning services, of food services, of any number of services within a hospital, that could have an impact on people's employment and certainly on their

compensation benefits, wages etc, if they no longer have employment. That's not a frontal assault on their collective agreement but it certainly is a way around the back door to achieve something else.

Although I appreciate where most of your folks work, and it's not in those sectors, do you have some concerns that there could be other ways, through a compliance order, not through a change in a collective agreement per se, that your members could either have their positions directly affected or their compensation affected as well?

1550

Ms Young Evans: Many RPNs are represented by CUPE. We have thousands, actually. RPNs are in service unions such as this; they aren't represented by ONA. We have about 100 who are represented by ONA; the rest are in about 15 to 20 different service unions across this province. So in effect, some backdoor things could be done. But the only instance I could think of, Ms Martel, would be if somehow the collective agreement was such that they contracted out, and if they did that and they went to an agency for nurses instead, they'd actually be paying more than what they'd be paying those who are in the collective agreement. So it would end up costing the hospital more for RPNs if they did something like that.

Ms Martel: Which is what they were doing during SARS. I appreciate that a number of folks might be organized through CUPE, but generally RPNs wouldn't be involved in food services or laundry provisions. That's the point I was trying to make. So an amalgamation of those services would not directly impact RPNs.

Ms Young Evans: Not unless they're working as a unregulated care provider.

Ms Martel: OK, thanks.

Ms Wynne: Thanks for your presentation. I'm just going to make a couple of clarifications and then Mr Duguid has a question.

I'm glad you agree with the notion of increased accountability, because I think this bill comes from two places. There's a lot of money going into the health care system and people feel that it just isn't working the way it should. What we're trying to do is get a handle on why that is, how we can help institutions to move in the direction that we all want to go, which is healthier people in a healthier community. So that's where this comes from.

The second place it comes from is a desire to start to shift the focus on to community health as well as hospital provision of health care. So what we're trying to do is get a sense of where those dollars are going and how they might better be spent. So that's underpinning this. There's absolutely no intention to vilify anybody or to pick a fight. As you heard from the minister's remarks, the language that seems to do that is going to be modified. I just want to be clear about that.

On some of the specific pieces that you identified, sections 13, 14 and 29 relating to the collection, use and disclosure of personal health information: First of all, there are going to be amendments to sections 13 and 14. The reason there is reference to the collection of health

information in this act as well as in Bill 31 is that the collection here is for specific purposes around the queue-jumping and extra-billing. So the need is to be able to access that information to figure out exactly what's going on. That's why it's in here. There may be further refinements that we need, but that's the explanation.

Section 27, just to be clear, deals with CEOs. We're not talking about individual nurses.

Then the other sections that you referenced, section 21, section 22, what we've tried to do there—and the amendments will come forward—is to bring some clarity to what the procedures are. So, yes, there may be the ability of the minister to enforce an order as the final step, but there's a whole lot that leads up to that in terms of what has to be done, what he or she has to consider, and that being available to people so they know what the procedures are.

Those are the changes that we're going to try to make. I hope they jibe with what your concerns are.

Mr Duguid had a question for you.

Mr Duguid: With the few minutes remaining—

The Chair: A minute or so.

Mr Duguid: A minute or so? That's OK. The question I have is on accountability within the system, to ensure that we can bring the significant changes that we want to bring to the system, changes such as ensuring that there are more full-time nurses as opposed to part-time, changes such as ensuring that the resources are going more into community-based than institutional-based initiatives and delivery. It's going to be difficult to do that. I think the accountability agreements may be one of the tools through which we may be able to start making some of those changes.

You indicated that you had some difficulties with the methods being used to ensure compliance. Do you have any suggestions as to how we can ensure that we have compliance with these agreements?

Ms Young Evans: If I can make a comment, and it goes back to some of Kathleen's comments and then into yours with regard to accountability, we have been talking to the ministry for the last three and a half years with regard to accountability. One of our main concerns, particularly with hospitals, is the hiring of RPNs and RNs. There are publicly funded facilities in this province that do not hire both categories of nurse, nor do both categories of nurse work to full scope of practice. You talked about nurses working to 70% full-time; this system can start saving hundreds of thousands, toward millions of dollars, if all nurses work toward full scope of practice and all those hospitals that are publicly funded are encouraged to hire both categories of nurses as well.

Nurses are overworked; they're burned out. What we want to see with this government is more accountability in how those health dollars are spent. We truly do not believe that more money needs to be infused into the system and that we can use that money much more wisely. We can even hire more nurses if the nurses that are there are used much more effectively.

Mr Duguid: But we need an effective way of making the stakeholders comply and be accountable.

Ms Young Evans: Yes. You should be looking at the Ministry of Municipal Affairs and Housing. When they deal with municipalities, they do a line-by-line budget, not global budgeting. We think that's one of the issues as well.

Mr Hardeman: Good afternoon, and thank you very much for your presentation. I just want to say that even before I had the opportunity to totally read Bill 8, I got a call from one of your members who was a member of CUPE. So I understand that you are represented by CUPE and concerned with the provision of being able to strip the contract and actually replace certain people with other people and so forth. That was in the bill.

Ms Wynne just mentioned the fact that this isn't about vilifying anyone, this isn't about a negative reaction to anyone employed in the system. This is about making sure that our money is properly spent in the health care system to make sure we're getting value for money. I wonder why the minister would introduce a bill—and maybe you can enlighten me—to provide the provisions for vilifying someone when we find them, rather than finding them first or looking at the system to see where the inefficiencies are and where we can make better use of registered practical nurses, as opposed to having all RNs; where we can find a better way to make our system work before we look at penalizing people.

The other thing I want to touch on I find very curious, and maybe you could help me. You've done a very good job of making a presentation. In most cases, a minister introduces a bill and then puts it out for public consultation. With this one, I have to commend the minister; it was put out to public consultation after first reading rather than second reading. It had more to do with timing in the Legislature than it had to do with when we heard the public presentations. But what's interesting about it is that it's not very often that a minister would introduce a bill, first or second reading, and then in between the time the bill goes to committee and before we hear the deputations, the minister comes forward with all the amendments he's going to make after we hear what the public has to say about it. It would seem to me to be more practical to wait for the public presentations and then, from what they've said, tell us what we need to modify in the bill in order to make it useful.

I find it very hard to understand why we would have a process that says, "Here's a bill. Come and make your comments on it. But incidentally, make sure you watch the news because you're really going to be making comments about a totally different bill than what is before you, because I am going to totally amend it. I realize there are a lot of problems in it and you're not going to like it, so we're going to do something totally different. But make your comments."

Ms Wynne: It's a work in progress.

Mr Hardeman: Yes. I was just told that it was a work in progress, but it wasn't very well founded in principle. It would seem to me that the minister must have read the bill before he introduced it and he must have had some idea of what he hoped to accomplish with that bill. When

you take whole sections of the bill prior to second reading—he's going to take out whole sections of the bill because he knows it's not going to do what the public will accept—I have to believe he was trying to slip something through to do things and hopefully it wouldn't get caught.

Did you find it difficult to make a presentation and to tell us what was good about this bill and what needed changing, recognizing the fact that what you were commenting on was not what needed changing? I don't know what the amendments were because I wasn't here for that part of the committee, but there's a whole new ballgame with all the amendments the minister is putting forward. Did you find that difficult?

1600

Ms Young Evans: We wanted to make sure that our comments were known on the original writing of the act. As Ms Martel has suggested, we are going to pick up and see some of the amendments. We had actually talked to the minister about some of those amendments, so we knew some of the things that were coming down. I think a lot of this is perception; a lot of this is explanation. As we work with our own bodies in nursing, I think sometimes intent is one thing and what actually is meant is something else. So I would hope that what the minister is trying to do is to put things out, see how people are understanding this, and further clarifying from there. I'm not defending his position. As I indicated before, I think there are some other issues that need to be dealt with in the accountability section as well.

The Chair: Thank you, Ms Young Evans, and thank you, Ms Bridle, for coming today.

CARE WATCH TORONTO

The Chair: Our next delegation is from Care Watch Toronto. We've got Bea Levis, Judy Jordan-Austin and Bernie Berger. Please come forward and make yourselves comfortable. You've got 20 minutes to use any way you see fit. It's entirely up to you. After the presentation, if there's any time left over, we will use that time among the three parties to perhaps ask you some questions. I'd ask that you identify yourselves for the Hansard record. The floor is yours.

Ms Judith Jordan-Austin: Thank you very much, Mr Chairman. My name is Judith Jordan-Austin. I'm a past president of Care Watch Toronto. To my left are Bea Levis, the present chair of Care Watch Toronto, and Mr Bernard Berger, who is a board member, and we have a few cheering people in the back. We're very appreciative of being able to speak with you this morning—this afternoon. I'm sorry; it's been a long day—and would like to express our thoughts and concerns about Bill 8.

I would like to make something abundantly clear at the very outset. Care Watch Toronto is a voluntary organization. Although some people have been professionals in the past, we work as volunteers and try to give a strong consumer voice to the whole matter of health care. We are deeply concerned about the quality of care and social services in Toronto and in Ontario.

We are also very concerned about the organization, delivery and quality of community-based long-term care. We want to improve the quality of life for care recipients and family caregivers. We want to ensure that such care is comprehensive, responsive to the needs of the individual, equitably accessible and of the highest quality. To this end, we endeavour to influence public policy regarding the development and maintenance of high-quality, publicly funded programs and services that allow the frail elderly, the chronically ill and the disabled to remain in their own homes as long as possible.

This said, we have some concerns about Bill 8, which does nothing at the moment, since we don't know the amendments, in our view to increase democratic input or improve accountability to the people regarding our health care system, so valuable to us all.

It has been presumed, and it makes sense in relation to Liberal campaign promises—although we don't expect all 243 to take place immediately—that this bill was intended to enshrine the Canada Health Act in Ontario law, create a health council to monitor health services and provide accountability which prohibits the development of a two-tier health care system.

The bill, while it contains a few important provisions, does not accomplish these objectives. That is our feeling. For instance, it does nothing to enhance the possibility that our constituency, namely today's seniors, who are growing in number, or future generations as they age, will be able to age in place with dignity and the greatest possible independence.

More specifically, we are concerned with the following sections of the proposed legislation. In the preamble, on first reading, this section appears to support all the positive features of our publicly funded health system, but it does not mention or make any commitment to reduce or eliminate the negative features such as the steady encroachment of P3 hospitals, use of for-profit services, private MRIs, delisting and user fees.

As an example, the statement "Recognize that access to primary health care is a cornerstone of an effective health system" we believe should read, "Recognize that primary health care reform must be the cornerstone of an effective health system."

Home care is mentioned, along with pharmacare for catastrophic drug costs, as though it is a secondary issue. Home care must be recognized as a vital component of a community health care system and must be funded as such. If you're concerned about dollars, I'm sure you're aware of the research that has been done that shows that home care in effect costs much less than institutionalized care and allows people to live in their homes in dignity.

Part I, the Ontario Health Quality Council: The council, as set out in part I, does not appear to have the right to make recommendations. One wonders why it is even considered. The process of member selection should be defined. The council should be at arm's length from the government, as is the national health council. We believe that half of the council membership should be from the community as defined in part I, clause 2(3)(c). The

process of selection of community members should be outlined. For-profit service providers should be excluded.

Part II, health services accessibility: To a large extent, this part incorporates the pre-existing provisions of the Health Care Accessibility Act, which forbade extra-billing by physicians. The issue of block fees charged by physicians is raised, but it is not clear whether the intention is to ban or regulate them. Our position is that they should be optional and regulated.

Part III, accountability: A number of people seem to feel that this is totally unacceptable because of the almost unlimited power it gives to the minister and the government. The opening sentence of the preamble to the bill reads, "The people of Ontario and their government...." This section, at the present time, effectively deletes the people of Ontario. We're sorry to say that the resemblance of this section to the omnibus bill passed by the previous government is rather alarming.

Thank you for inviting us today. If there's anything further we can do in helping your deliberations, please call on us. We congratulate you on beginning to address the health care needs in Ontario. We hope that our concerns and suggestions will be carefully considered. If you have any questions?

The Chair: Thank you very much. You used up about eight minutes, leaving us with 12, starting this time with Ms Wynne for four minutes.

Ms Wynne: Thank you for coming here today. Just so we're clear, the amendments are not finalized. You made a comment about not having seen the amendments yet. The reason for that is that they're not finalized. We're still in process. We've got three more days of hearings. So as I said earlier in a side comment, it is a work in process. The fact that we brought the bill out after first reading means that there is a large window of opportunity to make changes.

On the issue of the health quality council, the idea is that there would be a reporting to the public of the direction that we're going, how we're doing against standards that have been set. You said, what's the point of having the health quality council? I guess the point, as we see it, is that there would be this gathering together of information and it would be quite clear whether we're achieving the goals that we set out or not.

1610

Ms Bea Levis: We feel that the health council could have a very valuable function, as does the national health council, in being able to monitor and to keep a tab on and make accountable the steps the government takes in relation to this provision of service.

Ms Wynne: And for you, that would be the ability to make recommendations? Is that what you're—

Ms Levis: Without the ability to make recommendations, it seems that it's quite toothless.

Ms Wynne: OK. I think the idea is that there would be pressure that would be applied because of the information that was gathered, but we take your point. Thank you.

I wanted to make another point about the reference to home care in the preamble. I think it's important that we all understand that this bill is not meant to do everything that we promised, obviously, in the health care section of our platform. This is a step. The reason that home care and catastrophic drug care are mentioned in the preamble is that this is the future of medicare act and we all know that provision of adequate home care is a huge part of what we must do. That's why it's there, because this bill sets a framework for what needs to be put in place. The point of the bill is to get a handle on where those dollars are going and to begin to shift the emphasis, because we know that the provision of community health care is inadequate.

Does it make sense to you that this could be a first step to get a handle on what it is we're doing, how the money is being spent, how it could be better spent and to start to make that shift? We just heard a presenter say there are hundreds of thousands of dollars that could be saved in the system. That's the kind of thing we're looking at, because our focus is on that community care.

Ms Levis: Yes, we're very glad to hear that.

Mr Bernard Berger: I think one of the things that troubles us is that what began some years ago—not that many years ago; I think with the NDP government—as a program of home care, it made sense to help individuals who were disabled either by age or physical disability in their homes—home care services such as cleaning house and cooking, taking people to the doctor and so on. Because of the pressure put on these services by hospitals that are discharging their patients while they still need intensive care, that program is gone and a lot of people have been warehoused who could have stayed in their homes.

I think everybody here probably understands that the process of deterioration that takes place with aging intensifies in a warehouse, in an institution, and it's much slower when you're living at home among familiar things and so on. That's what our concern is. Our major concern is the well-aged who are living in their homes and are going to be kicked out because they don't have services.

Ms Wynne: That's the culture shift we're trying to begin. Thank you for your comments. I've probably gone over my time.

The Chair: No, there's about a minute left for Mr Duguid.

Mr Duguid: I just wanted to make a comment. I wanted to really thank you for coming here today. We hear from a lot of people and we have a lot more to hear from on this bill, but people who directly represent just the consumer, which is your mandate, are few and far between in the system. Your input is extremely valuable to us. I just wanted to say to you, please stay engaged in the process on this bill and on others, because there are far too few voices for the consumer in this process. I guess that's what our job is, for everybody around this table, but we rely on you to help us in fulfilling those duties. So I thank you for your efforts. They are very much appreciated.

Mrs Witmer: Thank you very much for your presentation. It appears to me, based on your comments, that this bill has not met the objective of the original press release the government issued saying that this bill was to outlaw two-tier health care in Ontario and stop creeping privatization of health care, because in your preamble you speak to the fact that you don't see any evidence of that.

Every time I listen to the government I hear there is a new reason, another reason why this bill has been introduced and I ask myself, if the objective is to use taxpayers' dollars in the best way possible, which I agree with, why didn't we have a consultation before we introduced a bill? I think we all support best use of tax dollars and we support accountability, but certainly this was a pretty draconian bill to introduce if that was its objective.

I would just ask you about your position on block fees. You have stated here your position would be that they would be "optional and regulated." So you don't support the elimination of block fees?

Ms Levis: Many of our members, because they are very clearly dependent upon their family physician and because there are very few community health centres around that provide salaried physicians and also make provision for all the extras—which, by the way, we're also concerned about—felt they couldn't put themselves in the position where the physician would refuse to serve them if they refuse. However, there are problems with people who can't afford to pay the block fees. It's all very well for middle-class and other, wealthier people to be able to do it. That's why we feel it should not only be optional but regulated, so people who cannot pay, for one reason or another, would be allowed to continue having their service without payment.

Mrs Witmer: I appreciate that explanation.

On the issue of accountability, you mentioned that many people have said that section is totally unacceptable because of the unlimited power it gives to the minister and the government. We know that that power is unprecedented and never seen before. Then you say there needs to be a change because you're concerned about the word, "the people of Ontario and their government." What type of change would you make to that in order to ensure accountability to the people of this province and the need for the public interest to continue to be protected?

Ms Jordan-Austin: I don't want to get into a debate with anyone today; I don't think that's our purpose here. But you had said it's never been seen before. The reconstruction of the CCACs deliberately did away with any community input. Our feeling is that community input is extremely important. We feel, as the recipients of home care and as the people who have to do something about home care, that we should be involved in the process of deciding what, how, when and where.

Mrs Witmer: How would you change the preamble? It's in your last part.

Ms Jordan-Austin: The preamble?

Mrs Witmer: Yes. It says, "The people of Ontario and their government...." Then you say, "This section

effectively deletes the people of Ontario." I guess I'm asking you, how would you change that to make sure it reflects what you think to be important?

1620

Ms Jordan-Austin: I don't know that we'd change the preamble. We might wish to change some of the other parts of the bill. Bea, do you want to speak to this?

Mrs Witmer: I'm not sure what your line means when you say, "This section effectively deletes the people of Ontario."

Ms Levis: I think we're dealing with here, although we didn't spell it out, the unlimited power that is given to the minister in many respects. Some of those respects have been spelled out by people such as the last two presenters I heard here this afternoon.

The thing we want to make sure of is that there is input from various sections, providers and consumers into the various aspects of providing health service that we felt this bill didn't provide, as it reads now.

Ms Martel: Thank you for being here today. You said, "The bill, while it contains a few important provisions, does not accomplish [the] objectives." Let me give you my take, for what it's worth.

I think the preamble is great—who could not support a preamble that talks about our most cherished institution, medicare?—but it was done as a public relations exercise. I don't think it's an accident that this bill was introduced on the first anniversary of the release of Mr Romanow's report. I also don't think it's an accident that many of the things he talked about in his report make their way into the preamble. I only wish that some of the details to put it into effect actually appeared in the bill.

I'm quite worried about the contradiction between the preamble and what is or isn't in the bill. For example, the preamble talks about continuing to support the prohibition of—one of the examples is user fees. Except that we have the Minister of Finance right now openly musing about the possibility of changing the universal Ontario drug benefit plan and perhaps implementing a means test so that more wealthy seniors can actually pay for their own drugs. Do you see the contradiction between what the preamble says and what the government is currently involved in?

Mr Berger: Maybe this is sacrilege, but we seniors—at any rate, those of who are in Care Watch—see nothing wrong with increasing taxes, because taxation is a progressive movement, not regressive. User fees are regressive.

Ms Martel: Thank you.

Mr Berger: Those that got, pays, and those that ain't got, don't pay. That's the way we would like to see it.

Certainly we are concerned, as the government is, about the billions of dollars in deficit that they've inherited. But taking it out on the backs of the citizens is not the way to proceed, by introducing user fees or delisting services. We really feel very strongly—and none of us are millionaires—that the way to overcome this deficit is to increase taxes, run a deficit for a little while, and eventually you pay off your debt. That's the way we feel.

Ms Martel: Also in the preamble, it says, "Recognize that access to primary health care is a cornerstone of an effective health system." Yet the bill is silent, for example, on the establishment of more community health centres, which have proven to be a very effective, cost-efficient manner to provide primary health care. Are you concerned at all about the preamble that talks about primary health care and the body of the bill that doesn't reference primary health care or CHCs, anywhere?

Ms Levis: We are certainly concerned, but we did try to address just the points that were in the bill. We do make representations to the government on primary health care and on the establishment of community health centres, but we did not put it in this.

Ms Martel: It points out the problem of what's not in the bill, so it's hard to comment on those things.

The Chair: Thank you for attending today. We certainly did enjoy and appreciate your input.

Ms Jordan-Austin: Thank you very much for having us. We appreciate the consultations and we hope we'll have more.

The Chair: We will.

CANADIAN AUTO WORKERS

The Chair: Our next delegation comes from the Canadian Auto Workers. Paul Forder, director of membership mobilization, is with us, and Nancy McMurphy and Corey Vermey. Please come forward and make yourselves comfortable. Same rules as everybody else. You've got 20 minutes. You can use it any way you see fit. At the end of the presentation, if there's any time left over, we'll be sharing that time among the three parties. You've got the floor.

Mr Paul Forder: Thank you very much, Mr Chairman. I want to bring you greetings on behalf of our president, Buzz Hargrove, the quiet, soft-spoken leader who has a real sensitivity to health care issues these days. He slipped and fell on a recent trip to the Northwest Territories and is laid up for four or six weeks with torn ligaments and muscles, and he's just being cranky, or he otherwise would have been here himself. So it kind of takes on more meaning for us.

Nancy McMurphy is our executive board member and also president of her local union—28 years' experience in the health care field. Corey Vermey is one of our researchers, who has spent 14 years working with this issue, and health care is part of his assignment. We welcome this opportunity.

It's nice to be back in the Legislature, having some meaningful dialogue. Eight years—it's been kind of cold out there, I can tell you, and we start to feel a little bit more appreciated as we do have some dialogue. We think it's important to keep things fluid. We're not going to tax the committee's time by going through our presentation word for word. We trust the members will do their work, and the staff, to look at our more detailed suggestions. We do have a couple of key points we'd like to make with the limited time that we do have.

We welcome the minister's commitment to amend various sections of Bill 8 based on the concerns expressed. The amendments are significant and address many valid concerns about the scope of Bill 8 and its intended impact on health care workers.

Expressing our public commitment to the future of medicare requires that we move forward in a positive, co-operative spirit with workers in health care and equal partners in pursuing quality, improvement and patient and worker safety in our public health care system.

We notice the whistle-blower protection section. The minister has addressed that today. We appreciate that and I'll skip that paragraph. We're comfortable with what appears to be an honest and direct amendment to protect workers from any reprisals for coming forward.

The greatest threat to public health care, as recognized by the minister in his November 27 statement to the Legislature—"The pursuit of corporate profits weakens, not strengthens, health care by taking dollars and resources out of medicine"—is the creeping privatization of health care that the minister proclaimed would be ended by Bill 8. We think we have some room to grow here and to ensure that this in fact does occur.

Private health care threatens quality for the sake of profit, rationing access based on ability to pay and revenue generation. We believe it subverts accountability for the sake of commercial confidentiality and proprietary rights. But Ontarians need to ask themselves, does Bill 8 end the creeping privatization of health care?

Under part I, health quality council, the bill only provides for annual reporting on access, resources and outcomes with no mandate to assign responsibility or to offer assessment or prescription on improvements. I did hear some of the comments of the members about what they felt the intent was, but we think it has to be fairly explicit, and they have to be empowered to do so.

We require a competent and credible watchdog, a public agency that is able to offer a description, as well as a prescription, for change. The mandate of the quality council needs to, at a minimum, also include reporting on the impact and outcomes of for-profit health care delivery in Ontario. The health quality council should be the primary means for ensuring the social accountability of the health system, including the Minister of Health, in terms of access, quality, outcomes and resources to the people of Ontario.

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Under part II, health services accessibility, the bill largely incorporates the Health Care Accessibility Act provisions enacted in 1986 regarding extra-billing, as well as new provisions prohibiting queue-jumping and regulating block fees. We quite frankly suggested recommendations about reducing the fines and don't feel that is an appropriate way to go when you think about the fines in 1986 now being even lower. One has to question whether that is going to be the necessary disincentive to protect the system. We think the fines should be rethought and looked at, being at least equal to the 1986 provisions of the Health Care Accessibility Act.

The core issue surrounding block fees remains the adequacy of physician remuneration systems and the need to regulate non-insured services under the accessibility principle of the Canada Health Act. Of course, we vehemently oppose block fees. We see that as part of the problem and if we can address the stagnant income of physicians in a constructive way, that, we believe, will help resolve that particular problem.

Under part III, there's a typo here. You'll note on the bottom of page 1, it should say part III—we say "part II"—accountability. We welcome the commitment to provide for substantial amendments to the more contentious provisions dealing with accountability agreements and compliance directives. We expect the minister to amend the bill to make that explicit, and he has, from the notes that we saw today on his intention to table those amendments. We appreciate that wholeheartedly.

We support the intent to provide that accountability agreements will be negotiated, not imposed, on boards of designated health providers: hospitals, long-term-care facilities, independent health facilities—clinics—and CCACs. But we ask why the minister, in his remarks, did not include or specify for-profit private providers such as the public-private partnerships—P3s—home care agencies or commercial laboratories. Those were not listed.

There has been no open, public debate on the merits of proceeding with P3 deals. The continuing lack of transparency and disclosure surrounding the P3 arrangements in the Brampton and Ottawa areas is lamentable. The public must rightfully ask, where is the accountability to the Liberal campaign platform to close the door to private hospitals? We know you didn't open it, but we know you have the power now to close it, and we urge you to do so.

We submit that the proposed penalties under this section again should not be less, as we mentioned, than in the Health Care Accessibility Act of 1986. We also support the intention to require a 60-day consultation period, including legislative debate, of course, on the accompanying regulations to the bill to ensure full public and stakeholder input. While we welcome the legislation as a demonstration of the commitment to the principles of medicare, as with medicare itself, there are obvious and immediate areas where we need to strengthen and reinforce that commitment.

I'm going to ask Corey to deal with a couple of issues in the time we have left, maybe the preamble, and also, if we have time, the accountability question.

The Chair: You've only used up about eight minutes, so you've got lots of time.

Mr Corey Vermey: Thank you. What we are suggesting by way of the text in the preamble is to redraft that language. We believe that the language can be strengthened and our comments are directed at the context in which those remarks are made, where those statements are recorded in the preamble. By and large, there are some textual issues that we would have with, for instance, a consumer-centred health care system. Our union represents 180,000 members in Ontario; 20,000 are health care workers and 160,000 are workers in other

sectors. They do not see themselves as consumers. They see themselves as citizens and as patients, or residents, if they are retirees in facilities or receiving services in their homes. So we take exception to that.

Given that the Romanow exercise was to begin with a health care covenant, we think this preamble as drafted should be strengthened in light of the spirit of that covenant and, in fact, the spirit of the entire commission's findings, and put in as a statement of purpose, thereby giving the public and others, including the judiciary, a sense of the legislative purpose and intent behind this legislation to clarify the uncertainty as to what the transfer of power to the minister is all about.

So we had a few points in regard to the language of the preamble, but speaking to the council, we certainly join with those who would advocate for the council as contemplated by this draft legislation to be strengthened considerably, insofar as it becomes a primary vehicle for social accountability to the public in Ontario. Largely, significant sections of this bill are about the vertical accountability of providers to the Minister of Health, and rightfully so; there is that obvious accountability relationship. But we think what this legislation strongly requires is a very effective council that is able to ensure social accountability to the people of Ontario. To begin with, we would urge that one of the key functions of the council is to report to the public of Ontario on the extent of for-profit, investor-owned health care in Ontario: What are the number of clinics, what are the number of services, what is the billing in dollar terms that is occurring in the province and, as well, what are the impediments to access, what are the deficiencies in quality that we are encountering as a province?

We think that in order to achieve that end, of course, one has to look critically at the composition of the council. We advocate for increasing the size of the council. Most hospital boards in this province are in excess of the size contemplated for this council, which obviously has a very critical role to play—not that local hospital boards do not—given the jurisdiction they are contending with. We would specifically ask for two exclusions. One is already there in the legislation in terms of excluding the senior management of health care providers. We would also urge the exclusion of those who are on the public record as having attacked and continuing to attack the principles of medicare or who have a financial stake in investor-owned delivery of health care. We think that in order to be credible and to enjoy the respect of the people of Ontario, that is a very important exclusion from the council.

In addition to that, we would suggest that seats at the table of the council be reserved for representatives of the public. We think the experts, for instance, should be attached to the council by way of consultative mechanisms, subcommittees etc, at the reach and disposal of the council, but not on the body of the council itself. That would provide for far more effective accountability to the people of Ontario through a body that the people will see as being representative of the spirit of medicare.

Our view on this piece of the legislation is obviously to begin to develop in Ontario a mechanism by which the public can directly deal with the many policy issues and complexities around the provision and delivery of health care in Ontario. Obviously, as this area grows as a spending program and as a social need in our province, these policy debates need a forum. There is not, to the best of my knowledge, certainly over 15 years, a forum in Ontario where all stakeholders can present these matters and where a consensus can be reached in terms of which way to go forward on the many challenges we face.

Editorially, one very specific piece in terms of the bill: There is a reference to continuous quality improvement, which we understand as CQI in our union. I think this is brand versus generic. This is a very specific approach to quality. One can obviously find many consultants engaged in the implementation of continuous quality improvement, and it is a brand. We would urge that there be a commitment to quality. Our union is certainly committed to quality workplaces and quality products, but we have made the suggestion that instead of the reference to continuous quality improvement, the reference be to improving patient safety, enhancing workplace health and safety, and improving quality of service and outcome. We think that is far more specific and deals with the issue at hand, as opposed to promoting one particular approach of many that have some dubious record in terms of health care delivery. Thank you.

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Mr Forder: I'll call on Nancy to conclude our presentation.

Ms Nancy McMurphy: In conclusion, we commend the government for its commitment to securing the future of medicare in Ontario through adoption of several of the recommendations of the Romanow Commission. As the Minister of Health stated to the Legislature on November 27, 2003, in presenting Bill 8, the Romanow report came to one pivotal and irrefutable conclusion: "The pursuit of corporate profits weakens, not strengthens, health care."

The test of Bill 8 in recognizing the legacy of the deep and profound commitment of Canadians to medicare is the ability of the people of Ontario to hold their government and health care providers accountable for strengthening health care and resisting the creeping privatization that threatens access, quality and sustainability of universal public health care. The challenge for Ontario is to build an integrated, comprehensive public health care system, capable of delivering quality services and improvements, to ensure continuing accountability to Ontarians for their investment and commitment to medicare.

Mr Forder: We'd be happy to take your questions, the hard ones for the staff and the political ones for me or Nancy.

The Chair: OK, very good. It appears that we've got about six minutes left, so they're going to have to be brief questions from each, starting this time with Ms Witmer.

Mrs Witmer: Thank you very much, Paul and the other members of your delegation. You mentioned here on page 13 that you feel the general tone of the bill in part III is adversarial in prescribing powers to the minister and that it allows the ministry to act with total impunity, regardless of the consequences. What type of amendments would you like to see that would eliminate that adversarial position that has been enunciated in the bill? What are the key types of provisions that you'd like to see changed?

Mr Vermey: I think it's fair to say that the case needs to be made by the government as to why the powers of the minister need to exceed the existing powers of the Minister of Health. We haven't been party to that conversation as to why additional powers are required beyond those that are current. We know of hospitals in Ontario that have been brought under supervision; we know of long-term-care facilities that have been brought under supervision. If the intent is to extend to other sectors, we certainly would take note of that, but there is no discussion that precedes this legislation in its draft form to warrant a significant extension of power to the minister, through the normal process of the minister being accountable to the public in Ontario.

It is as much its presentation as its obvious drafted provisions—and others, obviously—that gave us concern. We have only begun now to look at the amendments in context of the draft legislation to see where the new line, the bright line, is being drawn in terms of the powers of the minister.

Mrs Witmer: You've had no discussions with the minister or ministry on this bill, then? Or you have?

Mr Vermey: We have brought our concerns to the attention of the minister's office but we've had no direct discussion with the minister.

Ms Martel: Thank you for being here today. Let me deal with your summary, second page, where you said you "support the intent to provide that accountability agreements will be negotiated, not imposed, on boards of designated health providers." Before you leave, Paul, I want you to grab a copy of the February 19 memo from the minister to Mr Flynn. We got it in Windsor last week. Take a good look at sections 22 and 23. Those are the proposed changes. I don't think you'll get any great comfort that these are going to be negotiated, because the words "compliance directives and orders" still very much appear as part of the minister's ability. So you'll want to take another good look at that. Despite what he said, I don't think they got the message.

Let me deal with privatization, because this, for me, is key. We've got a preamble that talks in glowing terms about publicly funded health services, and yet there is nothing in the bill that stops the P3 hospitals, there is nothing in the bill that ensures that technology in the private CAT scan and MRI clinics goes into the publicly funded, publicly administered hospital system; there's nothing that stops competitive bidding in home care. Given that there is nothing in this bill to support the provisions in the preamble, are you worried that in fact

there's quite a disconnect between what the government pretends it wants to do in this bill and what the government is actually doing with respect to private health care services in the province?

Mr Forder: For us, it's a major weakness. We feel the minister, the cabinet and the members have to address this frontally. This is our opportunity to do something about it. Suffice it to say that we didn't start it. We know who started it, and now we have to fix it. If there is a consensus across this province—and we believe there is a strong consensus to fix it, to stop it dead in its tracks—then there should be no room for P3s in our system. That is just the opening of the door. We have to find a way to make sure our elderly and someone who's in that baby-boom bulge who is going to need all these services down the road—it's imperative that we fix it now, before the bulk of the boomers start to move through the system and be savaged by what we would see as unfair treatment in terms of the ability to pay, in terms of access and in terms of block fees etc.

Ms Wynne: Very quickly, because Mr Craitor has a question: On the P3 issue, I just wanted to cite the language that's being used right now in terms of moving forward. The ministry is working with the Ministry of Public Infrastructure and Renewal on a framework that would be based on public ownership, public accountability and public control. I'm not going to ask you to comment on that, but that is what we're working on.

In the reporting process, what the council will report on, I just want to be clear. Are you suggesting that there also be a report on privatization, on for-profit? I wasn't clear on that piece. What are you looking for?

Mr Vermey: That would be an absolute. We would expect that actually should be written into the act. That would be no greater an obligation than is currently in legislation under the Canada Health Act, although we're not aware that the province of Ontario has reported in recent years to the federal government under the terms of the Canada Health Act on the extent of privatization in health services delivery as well as funding.

Ms Wynne: Do you put specific language for an amendment in your report, or have you done that? Could you provide us with some language that you might suggest? Mr Craitor has a question.

Mr Kim Craitor (Niagara Falls): Thank you. I would be remiss if I didn't say hello to my brothers and sisters, especially my good friend Paul. It has been a while since I saw you. We were on the OFL together when I was president of the Niagara Falls labour council. First of all, let me just say—and I'm certain my colleagues feel the same way: excellent presentation, great suggestions. The one thing that caught my eye—and I think you know it would—was the whistle-blowing aspect of it, which I always felt strongly about, even when I worked in the federal government. Paul, the comments you had: Can you just go over them again with me in terms of how you feel we can improve that section of the bill?

Mr Forder: We could file an elaborate suggested amendment to try to incorporate our view. In the min-

ister's statement dated the 19th, his intention seems to be very satisfactory, but you always have to make sure, as you know, that the legal people have an opportunity to do a cut, give a cut. As long as people are not subjected to any form of reprisals for coming forward, that is so commendable, it's so important, it's so necessary. We can see and we know the consequences for people coming forward when they don't have those kinds of protections. I would be happy to provide the committee with some of the suggestions from our legal department, who are much more adept at doing such a write.

Mr Craitor: I would like to get that.

Mr Forder: Good to see you, Kim.

Mr Craitor: You're still a good dresser; you're still a good speaker. You're just a little greyer. That's the only thing I noticed.

The Chair: On that note, thank you for coming today. We did appreciate your input.

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INDEPENDENT DIAGNOSTIC CLINICS ASSOCIATION

The Chair: Our next delegation is from the Independent Diagnostic Clinics Association. Neena Kanwar is the president, and she's joined by Teresa Kapitor, who's on the board of directors. Make yourself comfortable. OK, same rules as everybody else: You've got 20 minutes. You can use that any way you like. Any time left over, I'll split evenly amongst the parties. If you would introduce yourself for Hansard.

Ms Neena Kanwar: My name is Neena Kanwar. I am the president of the Independent Diagnostic Clinics Association. Joining me today is Teresa Kapitor. She's one of the members of our board of directors. I'd like to thank the members of the committee for allowing us to make this presentation.

I'd like to start off with a little bit of an introduction regarding the IDCA and then talk about Bill 8. The IDCA was founded in 1989 when the Independent Health Facilities Act was first introduced by the Liberal government. Independent health facilities are community-based clinics. They offer public access to diagnostic and ambulatory surgical services. Community-based clinics have been in existence in Ontario for over 40 years. Many of the current clinics that are licensed were in existence prior to the implementation of the Independent Health Facilities Act.

The IDCA is an organization whose membership is open to all owners and operators of independent health facilities. Since its formation, the IDCA had been primarily involved in the area of quality assurance and in assisting both the government and independent clinic owners in the effective implementation of the Independent Health Facilities Act.

Independent health facilities have been an integral part of the publicly funded health care system, as I mentioned, for over 40 years. There are approximately 1,000 independent health facilities licensed by the Ministry of

Health and Long-Term Care in Ontario. Approximately 50% of the diagnostic services provided in Ontario are provided in independent health facilities, which is equivalent to about five million diagnostic procedures on residents in Ontario annually.

There are independent health facilities in underserviced areas, in rural areas, for example, where hospital and physician resources may be limited or unavailable. Independent health facilities provide patients with an alternative to driving to large urban centres to receive needed services.

The IDCA is supportive and has always worked to improve and protect the public health care system. We recognize and support the Ministry of Health and Long-Term Care's efforts to ensure that the principle of accessibility contained in the Canada Health Act is protected and enforced here in Ontario. We are also supportive of the ministry's and the minister's efforts to entrench accountability as a cornerstone principle of Ontario's health care system.

We acknowledge and are encouraged by the minister's comments on the opening day of public hearings on Bill 8 one week ago and the draft amendments that followed last Thursday. We applaud Minister Smitherman on his commitment to a collaborative process, open dialogue and meaningful and responsive stakeholder consultations.

Despite our agreement in principle with the goals of the Ministry of Health and Long-Term Care in developing Bill 8 and with many of the draft amendments, we would like to outline some of our concerns with respect to Bill 8. We will address our concerns in the order that they appear in the bill.

Part I, the Ontario Health Quality Council: The first section of Bill 8 describes the purpose and composition of the Ontario Health Quality Council. The council is mandated to monitor the state of the health care system and report annually to the minister. Bill 8 prohibits board members and "senior staff" members "of a health system organization" from being members of the council. While the minister has agreed to define the term "health system organization" in the legislation rather than waiting for the regulations, it is still unclear which stakeholders will be excluded from participating on the council. The wording of the bill seems to suggest that any provider of insured health services in Ontario, including IHFs, would be considered to be a health system organization and therefore excluded from participating on the council.

In the minister's comments on February 16, he expressed concern that if health organizations were represented, they would merely represent their respective silos. Having sat on many committees, we agree that there are silos in our health care system and that in order to ensure that the council achieve its mandate, this silo mentality must be eliminated. However, health care service providers such as IHFs are uniquely qualified to identify and help solve problems in the health care system. Since IHFs deliver services directly to patients across Ontario on a daily basis in their local communities, they have the skills and the experience necessary to advise on the current state of the health care system.

Our recommendation is that Bill 8 should be amended to allow senior staff members of health system organizations to be members of the council, not as representatives of their particular organization's or group's interests but as individual members of the council with the appropriate knowledge base and skill set. The fact of the matter is that health care service providers such as IHFs are uniquely qualified to identify and help solve problems in the health care system. We strongly believe that Bill 8 should be amended to allow health system organizations to be members of the council. In the alternative, a structure or mechanism should be developed that will provide IHFs and other health system organizations with an opportunity to be consulted and to provide feedback or recommendations to the council.

There have been examples in the past where consultation did not take place and decisions were made. Two examples come to mind. First is the case of bone mineral densitometry, where independent health facilities were not consulted when this service moved from being listed under one section of the schedule of benefits to another section of the schedule. This resulted in an increase in utilization of over 100% within a one-year period. If we had been asked, we could have predicted that particular increase. This is all history; it was a while ago. The most recent example would be scintimammography, where a service that was initially not in the schedule of benefits is now in the schedule of benefits, but only the professional fee, and thereby access to the service has been affected. There are other examples that I could quote, but I'll stick to the two and move on to part II, health services accessibility.

In the second part of Bill 8, subsections 9(1) and 9(2) state that physicians and designated practitioners shall only accept payment from OHIP or in accordance with an agreement made under subsection 2(2) of the Health Insurance Act and that they may not charge or accept more than the amount payable under OHIP. This is inconsistent with existing provisions of the Health Insurance Act, which allows facilities to pay physicians directly for services performed by the physician to such person or entity as may be prescribed. The inconsistency has also created some confusion, and the IDCA has concerns about whether Bill 8 will prohibit IHFs from paying physicians directly for their services, as well as paying amounts for administrative services, quality control etc, in addition to OHIP billings.

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To give you an example, if a physician was to report a study, OHIP is billed and that physician gets paid, but for quality control reasons that study may be reported by another physician. It's not billable to OHIP, but the physician needs to get paid for looking at the study again. This is to determine the quality and inter-observer and intra-observer variability. That's just one of the examples where the IHF would directly pay the physician.

We recommend that the bill be amended to address this ambiguity, either by including a specific exemption or by revising section 9 accordingly to clarify that IHFs

may pay physicians directly and that payment for administrative services, quality control etc, in addition to OHIP billings, is permitted.

Under the minister's proposed amendments of February 19, payments are permitted by public hospitals and mental health facilities for insured services rendered in those facilities. However, there is no mention of IHFs, and we would request that we be treated in a similar manner to the public hospitals and mental health facilities.

Subsection 9(4) of the bill prohibits any person or entity from charging or accepting payment for the rendering of an insured service to an insured person except under the conditions provided or unless permitted to do so by the regulations. The term "designated practitioner" is left to be defined in the regulations. It is unclear how this provision will affect IHFs, since we're not sure if IHFs will be included as designated practitioners or as non-designated practitioners. Therefore, in our reading of this section, it appears as though they would prohibit the charging of facility fees by IHFs to the Ministry of Health under section 3 of the Independent Health Facilities Act.

Leading from that, since it becomes then an unauthorized payment under Bill 8, it would give the power to the general manager to recover amounts for unauthorized payments. All of the things that follow after that section would then apply to IHFs. So the lack of clarity of section 9 with respect to facility fees means that unless IHFs are categorized as non-designated practitioners or a specific exemption is included under section 9 for facility fees, the fees paid to IHFs will be considered unauthorized payments.

Therefore, we recommend that the terms "designated practitioner" and "non-designated practitioner" be defined in the bill. Either IHFs should be classified as non-designated practitioners or this section should be amended to include an express exception permitting IHFs to continue to charge facility fees under the Independent Health Facilities Act.

Despite section 25 of the Statutory Powers Procedure Act, subsection 11(4) of Bill 8 allows the general manager of OHIP to take steps to enforce his or her decision regarding the accessibility requirement by deducting future payments owing to a health care provider even where the health care provider has not yet exhausted all available appeals. There is a similar section in the Independent Health Facilities Act where the director of an independent health facility may withhold payment, but in that process it is only after the appeals have been exhausted. It is also a departure from the general principle, as set out in section 25 of the SPPA, where the enforcement of a decision is stayed until final resolution of the matter.

While a minor amendment has been proposed in this regard, our opinion remains that the general manager should begin to enforce a repayment decision only once the appeal process is complete, as is the current process under the Independent Health Facilities Act. This would

avoid situations where funds have been wrongly withheld when a health care provider is ultimately successful on appeal or found not guilty.

The initial inclusion of imprisonment as a penalty for individuals convicted of an offence under this section was draconian and unacceptable and we're glad to see that the minister is proposing to remove the potential for incarceration. The maximum penalties for offences as they currently appear under Bill 8, however, are significant and, in the context of IHFs, prohibitive. The proposed penalties exceed the annual net revenue of many IHFs, and in some cases actually probably exceed the gross revenue as well.

The IDCA has similar concerns about penalty amounts set out in subsection 29(4) and section 31. We are encouraged by the minister's intention to reduce the maximum penalties. However, since they are not yet defined, our comments stand.

Furthermore, we believe that Bill 8 should contain an exemption-from-liability provision which protects individuals such as directors and officers from liability as long as they are acting in good faith in the scope of their authority.

I'd like to move on to part III, accountability. Under part III of Bill 8, the minister has the right to require health resource providers and their executives to enter into accountability agreements, issue compliance directives to providers and health resource provider executives, and unilaterally alter the terms of employment, the terms of funding, of HRP executives.

In his February 16 remarks, the minister stated that he intends to include IHFs in the definition of health resource providers. The IDCA feels that this part of the bill gives the government the power to micromanage the operations of every IHF and to provide directions to the executives of IHFs. In addition to creating a very unstable working environment, these changes interfere with fundamental principles of corporate governance. Furthermore, in light of the highly regulated nature of IHFs, subjecting IHFs to accountability agreements and compliance directives is both extreme and unnecessary. IHFs are already highly accountable to government as a result of the licensing regime and the provisions of the Independent Health Facilities Act, which governs how IHFs must conduct their affairs.

In addition to the licensing, service and billing requirements contained in the Independent Health Facilities Act, the Independent Health Facilities Act also allows the director of independent health facilities to investigate and assess IHFs to ensure that the IHF regulations and limitations and conditions of their licences are being respected. If they are not, the IHF stand to lose its their licences.

The registrar of the College of Physicians and Surgeons of Ontario—I'll break down the accountability for IHFs into two sections; one is the quality section—has the mandate under the Independent Health Facilities Act to assess and set standards for independent health facilities.

In partnership with leaders in medicine, the CPSO develops clinical practice parameters and facility standards, and assesses all IHFs in Ontario on a regular basis against these standards to ensure that the best care and services are provided to patients. So in terms of quality, they check the quality of the images, the quality of the reports, the billing that is being done—everything, basically—with a fine-tooth comb. If the IHFs are not in compliance with any of these clinical practice parameters and facility standards, the director may revoke the IHF's licence at any time if the IHF violates the terms and conditions and fails to provide an acceptable standard of care, or otherwise fails to comply with the terms of the IHFA.

The Chair: You have about a minute left. Perhaps you can start to summarize.

Ms Kanwar: OK. In terms of financial accountability, the IHFs represent less than 1% of the total health care budget, and we are accountable financially to the Ministry of Health.

I think you have my presentation, so I'll leave the 30 seconds for questions.

The Chair: I would as soon you'd finish. I haven't heard a 30-second question yet. I think we'll pass on the question. If you do have anything to summarize, though, take the time.

Ms Kanwar: No, I pretty much said what we came here to say.

The Chair: Wonderful. I appreciate that. Thank you very much for coming today.

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ROBERT CAMPBELL

The Chair: Our next delegate is Robert S.W. Campbell, who is shown as being here on behalf of the Toronto Health Coalition but is actually here on his own behalf today.

Mr Robert Campbell: Good afternoon, Mr Chairman and honourable members. Yes, that is correct. I am a member of the coalition, but the official presentation was made, I believe, last week. So I'm presenting as a member but on my own behalf.

The Chair: No problem at all. Thanks for noting that. You have the same rules as everybody else: 20 minutes to use any way you see fit. If the presentation does not take 20 minutes, we'll use up that remaining time to ask you questions. The floor is yours.

Mr Campbell: Thank you. The copy of the bill that I have does not have a title, but I gather from the related material that the title is actually the Commitment to the Future of Medicare Act. I have read the draft bill and I have some comments about it. It seems to me to fall a good deal short of what should be present in essential legislation of this sort.

The principle of such a bill, of course, is without question one of the most important subjects that exist in the health care field, but there are some aspects of the actual drafting of the bill that I think, unless I'm mistaken—this

is entirely my own view—are not adequate for the objective of legislation of this kind.

One troublesome feature, in my view, is the preamble of the bill. It appears in the copy that I have of the draft Bill 8 as the initial—it is contained in the body of the bill, but under the heading "Preamble." Of course, it sets out some extremely important principles that are fundamental in the health care system. I believe they are reasonably comprehensive and accurate in the statement, with one or two exceptions, but the difficulty I have with this preamble, as it presently appears in the draft bill, is that it really has very little effect. It does not achieve an affirmative and legal status by reason of its allocation in the bill as a preamble.

In statutory draftsmanship—I think I'm correct in this—if I could just refer to the Ontario Interpretation Act, it states that a preamble "shall be deemed a part thereof," meaning the bill or legislation, "and is intended to assist in explaining the purport and the object of the act," which is clear enough. However, the preamble that is stated in this bill, in my view, is really a crucial definition of the purpose, the objects and the principles of the legislation. If that is so, then it is far too crucial to regard merely as a statement in a preamble.

With regard to the courts with respect to preambles of statutes, the preamble has a very qualified effect. It really is not much more than a general expression of the direction of the legislation. It has very little interpretive significance or value. The result is that a preamble cannot change the fundamental enacting provisions of the statute itself. Consequently, if the legislation is put into force as it presently exists, it seems to me that we're working almost in a kind of vacuum.

The solution, in my submission, if it has not already been suggested as an amendment, is that the preamble be brought into the enacting part of the legislation and made part of the statute. In that way, it serves a number of functions. For one thing, it gives the health care council that is established by the legislation the crucial statutory definition, standards and the criteria that it requires in order to carry out its functions, one of which of course is reporting. That, I think, is one of the main preliminary comments that I would have in connection with that part of the legislation.

The next impression I have with respect to the legislation is the functions of the health quality council. Its principal function is to report periodically on the status of the health care system. However, it seems to me that the functions of the council should go well beyond this.

The council should, in my submission, also be given investigative power, not just, as the legislation states, to monitor and report, but to investigate, because it may well be one of the most elementary difficulties that the council encounters, not to have the ability to carry out its own inquiries as to compliance with the standards of the system.

1720

There is one very general aspect, but perhaps I could deal with it now. While it is not strictly, I suppose, within

the confines of this bill, it's certainly the basis of the whole health care system, and that really is the matter of the financing of the health care system. As I gather it, the government is encountering financial difficulties and is suggesting a great many, I think, crucial changes in the system to deal with this conundrum in the way of suggested reductions and delisting of various services, various devices of that sort.

The question, of course, comes down simply to a matter of funding. As I conceive it, the situation is that the cupboard is bare financially and there has to be some way of making ends meet with respect to providing the means for the health care system to carry on.

The one solution that seems to offend the government is the matter of taxation. The suggestion I have is very obvious: We've got to raise taxes in order to fund the system. Taxes, in my opinion, are the price we pay to live in a progressive democracy. I don't think the general populace would shrink from agreeing with some general increase in taxation. The other aspect of course is that the Romanow commission made quite plain that the system as a whole depends on progressive public taxation. This, I think, should be the whole basis of Canadian health care. It has been in the past, but that has certainly been compromised through the years in a great many ways.

The one aspect with regard to funding of the system that I think should be touched on, if it has not already been done, is the question of capital financing. My suggestion—it's certainly well known as a method—is to make use of the Bank of Canada. The Bank of Canada Act, clause 18(j), contains the ability and power of the bank and the provincial government to negotiate loans for the purpose of public expenditures. Certainly this, I suggest, is one of the main ways in which the system could be helped over difficult periods.

Another suggestion—I don't know whether this actually has been carried into effect but I believe the suggestion has been made—is that with respect to the financing of public accounts and accounts with respect to the health care system, resort be made to the modern and intelligent way of accounting, I would say, which is accrual accounting or capital accounting. In this way, at least we would know how the system is doing. As it stands now, I believe there is a transition going on, if I'm not mistaken, in that respect.

These two aspects of financing, I think, are part of a system that was part and parcel of Canadian financing in the past. We financed World War II entirely through the Bank of Canada at the end of the Great Depression and not only managed to come out on our feet, but we were able to finance the transition from a wartime to a peace-time government through the same method.

There is one other aspect, I would suggest: the matter of audit. I think there is a reference in the bill to this, but I don't see anything that would require the council to carry out audits or require audits of the private sector part of the health care system and report to the Provincial Auditor. If that's not in place, I certainly think it should be. Not only that, I think any report that is made in that

fashion, if it were, should be submitted by the Provincial Auditor to the federal Auditor General. I don't see anything in the bill about that.

A subject that's very bothersome, especially for some groups, is the matter of free-standing clinics and the method of privatizing, in effect, part of the health care system by allowing these entities to come into being. This seems to me to be quite contrary to the thrust and spirit of the health care system, which is essentially a public system. Yes, there are private providers, of course, but the system has been privatized well beyond anything that existed in the early stages of health care. The trend toward intensifying that kind of transformation in the system, I submit, is unsound. It's certainly destabilizing. We have a kind of chaotic situation now, with the disparities in the state of provincial health care systems and the federal government. The right hand doesn't seem to know what all the left hands are doing. It seems to me that much of this is the pressure that has been building up for many years to allow a privatization of the health care system, which I submit is entirely wrong.

The people who I think are most emphatic with respect to that process are the ones who have the most privatized system presently in place, and that of course is the Americans. The American health care system is a glaring example of what could happen in Ontario. They have problems of almost insoluble difficulty—

The Chair: One minute.

Mr Campbell: Thank you.

There is no real end in sight. Some of the critics of the system—and I have no doubt this has been referred to before the committee. The article in the February 2 issue of Time magazine about the crisis in the American health care system over the cost of pharmaceuticals and drugs, that kind of thing, clearly states in so many words that this is a crisis and that the American public is being left to a kind of game of chance, which is really something I think should be a salutary warning to legislators in this province. I don't think we should go further in that direction, and I don't think it's necessary. There have been many studies carried out that indicate, for one thing, that in comparison we have a much superior system in Ontario, dependent on the fact that it is a public one, not a private one. Consequently, the notion that private health care is superior is exploded in many American studies by authorities from Harvard and Yale University. It doesn't exist in that form.

The Chair: That would be a wonderful note to end on. Thank you very much. We appreciate your coming. Unfortunately we have no time for questions.

1730

TORONTO DISTRICT HEALTH COUNCIL

The Chair: If we can move on to our next group, the Toronto District Health Council, we have Scott Dudgeon here today, the executive director, and Mimi Lowi-Young, who is the chair. You have 20 minutes to use as you see fit. Any time that is left over from your

presentation will be used by the other members of the group to ask you any questions they may have. If you would introduce yourself for Hansard, the floor is yours.

Mr Scott Dudgeon: Thank you very much to the standing committee for the opportunity to present to you. I want to introduce Mimi Lowi-Young, the chair of the Toronto District Health Council. I'm Scott Dudgeon, the executive director.

I'll tell you a little bit about district health councils. I expect that some on the committee have intense knowledge of the health care system from the perspective of a user and some from a more concentrated view of the health care system. District health councils have been around for 30 years providing advice to the Minister of Health on the health needs of their respective communities. There are 16 in Ontario now. Toronto District Health Council is the smallest in area, but it's a fairly complex city and it has some very complex issues. Our job is to make sure that whatever changes take place in the health system make sense for the people of Ontario, that whatever issues emerge in the delivery of health care are brought to the attention of the minister and solutions are provided. We do our work through extensive relationships we have with providers and consumers throughout the breadth of the system and through a board that's comprised of equal measure of providers and consumers. It's kind of a unique arrangement; an excellent tool for governance. We do it through the hard work of a very small staff of professional planners and epidemiologists who have expert knowledge of health system planning. So that's who we are.

We are happy to have this opportunity to talk to you about our views on Bill 8 and to offer you some advice from our rather unique perspective. We want to start by applauding the government for Bill 8. We think that the commitment to the future of medicare in Ontario, as expressed in Bill 8, is solid, noteworthy and commendable. We think that accountability is vitally important and that putting instruments in place that reinforce accountability is similarly important. We have an accountability agreement at the district health council that was an agreement between the district health council and the then Minister of Health, Honourable Elizabeth Witmer, that stipulates what's required from either party. It stipulates the roles of the minister, the ministry, the chair, members of council and the executive director in very clear language. It's clear about the length of the term of the contract and other arrangements. We think it serves as a reasonable model for accountability agreements with other elements in the system.

In the situation we're in today, we need to have absolute clarity as to what is expected of health care providers and others in the system and what is expected in terms of what can be delivered for the amount of money that's being spent in pursuit of meeting service objectives. In any agreement of that sort, there needs to be a clear definition of what the rewards and consequences associated with the delivery of the items in the agreement are. We think it's commendable that the gov-

ernment intends to proceed in this fashion. We're going to come back to accountability in a moment.

The second thing I wanted to comment on was the advent of the quality council. We think this is absolutely essential, and it's tied very closely and logically to the notion of accountability, because there is too little intelligible information on the performance of the health system that would allow you to monitor the performance through the accountability agreements. I'm thinking particularly in the community sector, where the metrics are just not solid enough to be the basis for very rigorous accountability agreements.

We need to have a quality council that identifies what the measures are that need to be put in place to make sure the system itself is delivering what it needs to in the form that it needs to be delivered in to the people who require it. We think that it fits quite nicely with the national quality council, and we're seeing a sort of cascading of measurement responsibility from the federal to the provincial to the more local geographic unit, which at the moment is district health councils. We're quite happy to continue to play a role in this.

A few years ago the Toronto District Health Council played a leadership role in creating the first local health system monitoring project. We did this because our council took the view that it couldn't adequately report to the minister on the performance of the health system unless it had a good sense itself as to what the impact of the reforms that have been taking place so far has been. Are those reforms being enjoyed by the entire population to the same extent? What are the areas that we should focus on to plan for further system improvements? We commented on about 70 performance indicators that identified issues of health care utilization, issues of health status and descriptors that set the context so that you understand the basis of the population on whose behalf the health system is arraying its services.

Since that time, we have worked with district health councils across the province to similarly develop local health system monitoring projects, which allows government and providers in various communities to get a handle on the context for what's going on in their areas on the basis of performance in other parts of the province.

Currently the people involved in this project are developing measures of inequity, in terms of measuring the extent to which services in Ontario are accessed evenly and equitably and in relation to people's actual need for those services. We're looking at such areas of equity as geographic distribution of services. Do people in the north have the same utilization rates for certain services as people in the more urban parts of the province? Do women have different issues with respect to accessing services than men? Do aboriginals have particular access issues relative to the rest of the population? We're going to be happy to be reporting on that in the fall of this year.

We think we can play a very vital role in supporting the work of the quality council. What distinguishes

district health councils and their work in this area is the rather unique blend of highly analytical work performed by our planners and epidemiologists and our highly consultative approach to planning, where we work with experts in the field to develop consensus on what's important and how to go about measuring it. So we're putting that on offer as something that will support the good work of the quality council.

The third point I want to raise is back to the issue of accountability. You will have heard by now, I expect, from many of the silos that characterize the system about what interests those silos in the area of accountability. What concerns me about moving forward in developing the system is, how do we break out of the silo orientation, and who's going to take responsibility for the delivery of health care at the system level? If I can take Toronto as an example, you're going to have accountability agreements with the 24 hospitals in Toronto, with the 22 community health centres, with the five community care access centres, and as this unfolds with the many hundreds of other agencies that exist in Toronto, who is going to be responsible for ensuring that the volume of activity that's described in accountability agreements is actually required? If you have a number of hospitals, for instance, that are making agreements with the province to deliver X volume of services on behalf of the residents of Toronto, how is government going to know that X is the right number of services required for the city of Toronto?

1740

Our job, our mandate and our responsibility is to make sure that there is a plan, and that's what we're working on right now: to develop a service plan that identifies for you what the needs are in Toronto between the years 2008 and 2016, to give us a reasonable planning horizon. On the basis of that plan, we're also providing for government's consideration a plan for reshaping the decision-making structure for the health system at the Toronto level. What we're going to be proposing is that there be a body that's responsible for planning, for negotiating agreements with the various agencies and for making sure that those agreements are done on a multi-party basis to make sure that for geographic units inside Toronto, hospitals, community health centres, long-term-care facilities and primary care physicians all have a way of binding their mutual obligations together on behalf of the residents of that geographic area and with the people of Ontario through the government. We think that something this committee is going to want to consider is, across the province, how are we going to make sure that there are mechanisms for system-wide accountability at the local level?

I want to finish on that note. I think that's maybe the most critical bit of advice that the Toronto District Health Council would like to offer you. I want to make sure that there's room for discussion. Thank you, and I'll take whatever questions you might have.

The Chair: That's wonderful. Thank you. You used up about 11 minutes. You've left us with nine, starting with Ms Wynne.

Ms Wynne: Hello. How are you?

Mr Dudgeon: Hello again.

Ms Wynne: I haven't seen you since 7:30 this morning. We have to stop meeting like this.

You talked, Scott, about the breaking-out-of-the-silo mentality. Can you talk a little bit about what the mechanism would be? How would you actually insert yourselves into that process if offered the opportunity?

Mr Dudgeon: That's an excellent question. I think people in the system look to us to take a system orientation. We've had an honest-broker role for years that only works in the current circumstances because we neither fund services nor provide services; we're noted for our objectivity and our skills in planning. People trust the district health council, and they work with us. I'm continuously impressed with the extent to which people are willing to give up their evenings and their family time to come and sort out how to improve access to neurosurgery, how to improve the delivery of palliative care or whatever issue we might be working with. So building on the trust that exists and our planning strengths, we're in a position to help government achieve that breakaway from the silo orientation.

What's really important, though, is for government to have the will to do that. It's not an easy matter. The system was not designed as a system. The silos evolved quite naturally and have pretty rigid walls around them. It's going to take tremendous will, effort and concentration on the part of government to break through that. I'm offering our assistance. We certainly wouldn't be in a position to do it without tremendous support from the government.

I think the most important step for government to take in that direction would be to focus on population. So the starting point of the discussions has to be, what does the population of that area—say, Toronto—need in the way of service? How do we know this? Can this be backed up with sound evidence? Then move from there toward the delivery of service. Prior discussions have focused on what additional services are needed. I'm suggesting that if we start with population and move toward service, that would be a corrective that would be very helpful.

The other thing—and I'll finish with this—is that we need to move the whole system at once. Through the last effort to restructure the health care system, the starting point was hospitals. The restructuring commission had the legal power to direct hospitals to do things. It had the force of law. The commission only had the power to make recommendations to government to change the other elements of the system, and those didn't happen as a single effort. There were delays in getting to the community pieces and there was a mismatch between getting objectives met because of the difficulty of addressing the whole system at once. So I'm suggesting you start with the population and use the system as the vehicle instead of the individual delivery units.

Mrs Witmer: Thank you very much for your presentation. I've always appreciated the work of the health councils in the province. I think they have a very import-

ant role to play. I guess part of what you've indicated here is that you see a unique role for yourself as far as supporting, for example, the creation of an Ontario Health Quality Council with a mandate of ensuring accountability in our health system.

When you talk about this, do you envision other councils in the province also supporting the government in this respect, or are you focusing solely in your remarks on the Toronto District Health Council?

Mr Dudgeon: I'm not in a position to speak on behalf of the other district health councils, but if you're asking if that's something that's conceivable, I think that we've demonstrated, through the last couple of years, a collective will to increase the level of intelligence that's available for government to make decisions by working together in data collection, analysis and interpretation. I think that district health councils—and this is my opinion—would welcome the opportunity to support the health council through their skills.

Mrs Witmer: Are there any priorities that you would see for a health council? We've seen that it's taking a long time for the federal council to get underway and what have you. What would you see a provincial council doing? What would be some of the first priorities?

Mr Dudgeon: My sense is, a high priority—I don't know that it's the first priority—has to be the development of meaningful metrics for measuring system integration. We all want system integration, but would we recognize it when we see it, and how do we measure progress in that direction? I don't think there is substantial agreement in any kind of finite way of measuring that. I think that would be my first priority, if it was my call.

Close to that would be just getting simple performance measures in place for the community sector, which is struggling to demonstrate its worth. We all know that the community sector does tremendous work, but how do you measure the value of keeping the frail elderly at home and autonomous and aging in place? How do you measure, then, the efforts that are taken by those agencies to accomplish that? How do you measure it in a way that gives them the tools to better manage their work and to look for opportunities for integration in support of doing that? So those are two areas that I think would be important.

Ms Martel: Thank you for being here so late in the afternoon. We heard the same in Ottawa, that there is a sense that district health councils want to provide support in whatever way, shape or form that may be to the council. You have set out where you have been heading. Clearly a great deal of work is being done on the local health system monitoring project and then in the process of developing a health system plan for Toronto.

My question would be, what is the status with respect to other district health councils? I'm not trying to undermine you by asking you to comment on the others, but I wouldn't have any clue of what the capacity would be of other district health councils to respond in a similar fashion where they are in terms of planning for health

care services in their own regions, which in many cases would be a lot bigger than yours geographically and present some unique challenges that way in terms of the delivery of services.

1750

Mr Dudgeon: Thank you very much for the opportunity to amplify a point that was maybe hidden in some of my earlier remarks. I think that in pursuit of government's agenda to improve on the delivery of health care, one of the things we need to do, whatever the goal is—and I assume the goals are all lofty—is to recognize the need for different starting points across the province.

Toronto's health system plan is predicated on a set of institutions and a set of agencies and organizations, some skills that we know to be on the ground and available for retooling, in pursuit of a better system. I know that in Sudbury you'd have a different configuration of services and a different set of skills and capabilities, just as I know that the issues confronted by the system in Sudbury or Kingston or Kitchener, or in Kenora for that matter, all have different priorities. I think we can all move to a more integrated system taking those different starting points into account.

District health councils are meeting tomorrow and are going to be looking at a common approach to take to government that would say there are fundamentally four sets of starting points that need to be considered: one would be urban, and that's the point that I was referring to for Toronto; one would be a starting point that deals with matching the capacity of the system to the rapid growth experienced in the greater Toronto area; a third one would be northern communities and the unique challenges they face, particularly with dwindling populations and an eroding resource base; and the fourth one would be rural populations.

What I'm suggesting to you is that in moving toward a single, very solid view of a more integrated system, let's take advantage of the different skills, the different resources available to district health councils and the different starting points available across the province.

The Chair: Thank you, Mr Dudgeon and Ms Lowi-Young. Thanks for joining us here today. We appreciate it.

MEDICAL REFORM GROUP

The Chair: Our last delegation of the day, the Medical Reform Group: Aaron Rostas, a member of the steering committee, and Bradley MacIntosh, another member of the steering committee. Make yourselves comfortable. The same as all the other groups we've seen today, you get 20 minutes. You can use that any way you see fit. If there's any time left over at the end of your presentation, we'll use that amongst the three parties to ask you any questions that we may have, up to the 20-minute limit. The floor is yours.

Mr Bradley MacIntosh: To start, I just wanted to describe the Medical Reform Group. It's an organization that was formed in 1979 and it's a group of approxi-

mately 300 practising physicians, medical students and other health care advocates. The MRG represents the views of its members on health and health care matters through research, public statements and consultation with other groups who share our aim of maintaining high-quality, publicly funded, universal health care.

The Chair: I've made an error. I forgot to ask you to introduce yourselves for Hansard.

Mr MacIntosh: OK, I'll get to that. But first—

The Chair: I think you probably should do it now because they're trying to record what you're saying and they don't know who's saying it.

Mr MacIntosh: OK. I'm Brad MacIntosh and this is Aaron Rostas. We're very pleased to be able to present our brief on Bill 8. As I was going to say, Aaron and I actually bridge over two parts of the Medical Reform Group because we're also founding members of a student chapter. We recognize the benefits of open discussion, political awareness and diversity, and we hope to share that with you today.

We're very pleased that the government is explicitly stating its support of medicare through Bill 8. Our presentation today will focus on areas where we believe Bill 8 can be strengthened and ensure that Ontarians receive the best health care possible.

Now Aaron is going to talk about parts I and II, and I'll finish with some comments on part III.

Mr Aaron Rostas: As you're aware, part I deals with the implementation of an Ontario Health Quality Council. We have a number of thoughts that we'd like to share on that. The Medical Reform Group strongly supports the development of a council to report back to Ontarians on the state of their health care system. We also agree with the proposed size of the group and we definitely support the notion of diversity among council members.

However, we believe that the appointment process as it's currently structured could potentially lead to the formation of a partisan council that is not sufficiently independent from the government. We go on to suggest a number of possible alternatives for that, and I'll allow you to look through those.

In general, we feel that the appointment process should attempt to mimic the appoint process of the national health council in Ottawa. The Medical Reform Group was happy to be involved in the process of implementing the national health council, and several of our suggestions were followed.

We also strongly recommend that the council's power to make recommendations not simply be limited to reporting needs. The Ontario Health Quality Council, as it's immersed in research in the health care system, is in a strong position to make non-partisan recommendations regarding health care system structure and function. For political reasons, as I'm sure you're all aware, governments must often focus on short-term cost containment goals instead of looking at longer term cost-effectiveness. An example that comes to mind is the previous government's attempt to palliate the problems of physician

shortage by increasing the number of positions in medical schools, but not following by increasing the number of residency positions in proportion to that. Currently, an article that just came out in The Medical Post states that this year, for the first time, there are in fact more people applying for residency positions than there are actual positions, forcing medical graduates to have to leave and go to places like the States. We're hoping that a strong Ontario Health Quality Council could make recommendations to look a little further down the road and help overcome some of these shortcomings.

The second part of the bill deals with health services accessibility. The Medical Reform Group strongly supports the notion that health care practitioners such as physicians only be permitted to charge OHIP for insured services. The Medical Reform Group strongly supports the right of the government to regulate block fees for non-insured services. However, we believe that the government should go one step further. We feel that the government should go beyond simply regulating block fees and ban them entirely. Recent news reports have highlighted instances where doctors have circumnavigated the College of Physicians and Surgeons of Ontario's block fees policy. For example, a recent Globe and Mail article reports that two doctors are charging their patients \$2,500 per year to receive care. This practice, which is reasonably common in the United States, is known as "boutique medicine" and has come under intense criticism across the border. The CPSO's own magazine reported that patients in one Ontario town were told by their physician's office that the doctor would not return phone calls unless they paid a block fee.

There are several important reasons why block fees should be banned. With thousands of Ontarians unable to find a family doctor, it's both irresponsible and unethical for physicians to limit their practices to those who will pay for their care. Furthermore, the number of physicians in Canada is significantly lower than almost all other G7 countries; Ontario specifically has the lowest number of family physicians per capita out of every single province in the country. The financial incentives that block fees provide further discourage physicians from taking on new patients.

Many of the items for which some physicians charge fees are in fact medically necessary. What are called "necessary adjuncts" in Bill 8 are essential to the doctor-patient relationship and we feel should in fact be insured services paid for by OHIP. These include such responsibilities as acting as a patient advocate, giving customized advice, renewing prescriptions and providing adequate transfer of care when a patient needs a new doctor.

A block fee will inevitably open the door to some form of boutique medicine. Non-paying patients may receive less of the doctor's time at appointments or less advocacy when they need an important diagnostic test. Due to the difficulty in monitoring block fees, as well as a natural reluctance of patients to complain about their

doctor, any block fee policy designed to simply minimize harm is unlikely to be successful.

If block fees are to still be allowed, the government should still ensure that necessary adjuncts, as defined by either the Lieutenant Governor in Council or the council itself, be excluded. Block fees should include only truly optional services, such as forms for summer camp, non-insured vaccinations etc.

Other recommendations to minimize harm include: Doctors who charge patient block fees should be required to post a government-designed poster in their office outlining what services cannot be included in the fees. The poster should explain to the patients how they can file a complaint if their doctor is violating this policy. The government should clearly state that doctors must not discriminate between patients who pay a block fee and patients who don't, neither in terms of accepting them in the practice nor in terms of the quality of OHIP-covered care that's provided. Finally, the government should permit itself the right to specify a maximum allowable block fee.

1800

Mr MacIntosh: The third item that we were going to speak to is the issue of accountability. In principle, the MRG is encouraged by the introduction of such an idea. However, we found it difficult to actually make recommendations in light of some contrasting initiatives. So there's the issue of accountability—which is nice—the language of which we support wholeheartedly. However, in Ontario, we feel that there's a commitment to finding new ways to pay for or deliver services.

So I call your attention to two examples where the MRG basically has a question to you, and we're wondering how these two examples fit into the context of accountability. The first example is the mortgage-to-own hospitals, which were previously called P3 hospitals; and the second example is the private MRI and CT scanners. We don't understand how these two items are incorporated into the context of accountability.

In the first case, mortgage-to-own contracts are still in negotiation. So the MRG recommends that you clarify how listed issues such as transparency, public reporting and trust get translated into practice in this context.

As the MRG has previously stated, we are opposed to governments embarking on temporary cost-saving mechanisms or means of delivering some sort of health service. One of our members, Dr P.J. Devereaux, has published several papers articulating the difference between private for-profit hospitals and private not-for-profit hospitals. In several studies he found, for example, an increased rate of mortality in private for-profit hospitals or increased mortality in hemodialysis centres. So with that as sort of the backdrop, we find it difficult to understand how this evidence will be incorporated into the accountability. That's a question we present to you.

The second item is the private CT and MRI scanners. That story is also quite telling, because as we've heard from the current scanners that are operating in Ontario, the issue of accountability is already missing. So how is

this proposed act going to affect the services, which I understand are currently in the form of renegotiation? Issues like documented adverse drug reactions or breaching of rules, protocols, such as administering contrast agents: These represent breaches of this bill. We're not sure how this would then be reflected. So that comes back to a problem with the bill in this section, and that is, the definition of a health resource provider is general in the sense that it could be a doctor, a community centre, a long-term-care facility or, as I've said here, these particular examples. So it may be useful to decide whether the issue of accountability is going to be generalizable to all the circumstances.

In closing, despite election promises by the Ontario Liberal government stating that they were not going to outsource health care services, this is not the reality. So we wanted to just introduce that as a glaring problem with this bill. We're disappointed in these steps, and we'd just like to acknowledge that in the context of accountability.

To summarize, we support the idea of an Ontario Health Quality Council, although we recommend some modifications as have been listed here. To ensure that all Ontarians have equal access to medically necessary care, the MRG recommends that the government ban all block fees. Finally, to ensure transparency, the MRG recommends that all accountability agreements that are drafted in part III be made public.

The Chair: Very good. Thank you very much, Mr MacIntosh. You've left us about six minutes, so we can probably get three questions in, three final questions of the day, starting with Mrs Witmer.

Mrs Witmer: Thank you very much for your presentation and your review of Bill 8. I'm not quite sure, though, of your position on block fees, because on the second-last page you come back and say that perhaps they should be allowed for non-insured vaccinations. I guess the truth is, if doctors aren't going to be reimbursed for these, how are they going to be paid?

Mr Rostas: There are certain medical processes that physicians do that I guess they do need to be reimbursed for. Examples might be a plastic surgeon doing a cosmetic procedure or something like that. But we see those as different from something where every patient is required to pay as just an aspect of their care; block fees such as photocopying services and things like that and the example of doctors charging \$2,500 per patient. Those were fees simply given essentially to belong to the practice under the guise of telephone costs and photocopying costs. We believe those sorts of fees definitely impair access to the physician.

Mrs Witmer: What about the non-insured vaccinations? Who pays for those?

Mr Rostas: In those cases, the patient would be paying for those, because I guess it's felt by the government that those are not medically necessary things. For example, someone travelling to a foreign country may need something. However, we're certainly not implying

that vaccinations that are medically necessary shouldn't be covered by the government.

Mrs Witmer: I think your points on the health council are well taken.

Ms Martel: Thank you for being here at the end of the day. We appreciate it. I'm just going to focus on your last point and relate a story to you that happened in Ottawa. When we were in Ottawa, I moved a motion to have the details of the lease agreement being negotiated between the government and the private consortium at the Royal Ottawa released so the public could have a sense of what was happening in that regard, because my concern is that if you don't release it now, once it's signed, sealed and delivered, there isn't going to be much anybody can do to change the details. One of the Liberal members argued against that motion, saying that would intrude upon confidentiality provisions and commercial confidentiality provisions and might cause the private sector consortium to flee. I would be very happy if they did because, quite frankly, if you're a supporter of medicare, you support publicly funded, publicly administered and publicly financed health care as well, something that is missing in the current P3 hospital proposals, both in Brampton and in Ottawa.

In terms of accountability and the lack of accountability of this government around those particular two mortgage arrangements—they used to be lease arrangements; now we call them mortgage arrangements—what is your concern as we go down the road when they're not included and we can't see the details of those commercial transactions, when we can't see the details of the commercial transactions involving the MRI and private CAT scan clinics? What is your concern about where we're heading with respect to medicare if we start to move in that direction and we can't see where that money is being spent or how much of it is being spent in a profit instead of on delivery of front-line health care services?

Mr MacIntosh: There are several components to answering that. The first one is that we know when we outsource services to the private sector, investor-owned businesses, that the service is not the same quality. In the case of the private MRIs, we know through anecdotal evidence, as documented by the Ontario Association of Radiologists, that patients aren't getting the same quality of care.

That's something that's happening at home in Ontario, but in general, the idea of privatization or P3 models, we know from the body of literature elsewhere—as in Britain, for instance, where they tried these financing schemes and they didn't actually work out well. The current government appears to be pigeonholed or backed

into a corner based on previous governments finding ways or looking for ways for business initiatives, so unfortunately they're dealing with the previous government's laundry.

Ms Martel: But they made a promise to cancel them. Let's not forget that during the election in order to get votes this government said they were going to cancel the P3 hospitals and the private MRI clinics, please.

Mr MacIntosh: So, the question is, are they reading the contracts, and if so—I don't know that. I've spoken to people in the Ministry of Health and, to my knowledge, I'm not sure if this is something that is getting the attention it deserves. That right there is a bit of an insult, based on what their election mandate was. Second, if it is such a priority, then by all means go and take ownership of these hospitals. It's cheaper. It's safer. You just have to have the political will.

The Chair: Ms Wynne, last question of the day.

Ms Wynne: I just want to make a couple of points. Your point about the disentangling of previous agreements, I think, is well taken. Right now there are two ministries working on the going forward in terms of new infrastructure. The Ministry of Public Infrastructure Renewal and the health ministry are working on any building going forward being based on principles of public ownership, public accountability and public control. That's the commitment. But in every sector in this government in this province right now, we're looking at arrangements and deals that were made previously. We're trying to unravel that. This bill is a step toward cleaning that up and pointing ourselves in a different direction. In that context, is it reasonable that this is a first step? We're trying to get some sense of where the dollars are going, to refocus on what health care should be in the province and to put a mechanism in place—this is really a process bill—that will start to talk about the direction we're going in and make that public to citizens in Ontario. Does that seem like a reasonable thing to do? It's a small question.

Mr MacIntosh: It took a long time for me to actually deduce the context of the accountability, so I would say that if your message is what you're suggesting, then you should vocalize that.

Ms Wynne: The accountability mechanism needs to be made clearer, and that is one of the things that is going to happen in our amendments. So it will be much clearer how that accountability mechanism will work. Thanks.

The Chair: Thank you for coming today, gentlemen. I do appreciate it. We stand adjourned until tomorrow morning at 10 o'clock.

The committee adjourned at 1814.



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STANDING COMMITTEE ON JUSTICE AND SOCIAL POLICY

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Mardi 24 février 2004

Standing committee on
justice and social policy

Comité permanent de la
justice et des affaires sociales

Commitment to the Future
of Medicare Act, 2003

Loi de 2003 sur l'engagement
d'assurer l'avenir
de l'assurance-santé

Chair: Kevin Daniel Flynn
Clerk: Susan Sourial

Président : Kevin Daniel Flynn
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LEGISLATIVE ASSEMBLY OF ONTARIO

**STANDING COMMITTEE ON
JUSTICE AND SOCIAL POLICY**

Tuesday 24 February 2004

The committee met at 1003 in room 151.

**COMMITMENT TO THE FUTURE
OF MEDICARE ACT, 2003**

**LOI DE 2003 SUR L'ENGAGEMENT
D'ASSURER L'AVENIR
DE L'ASSURANCE-SANTÉ**

Consideration of Bill 8, An Act to establish the Ontario Health Quality Council, to enact new legislation concerning health service accessibility and repeal the Health Care Accessibility Act, to provide for accountability in the health service sector, and to amend the Health Insurance Act / Projet de loi 8, Loi créant le Conseil ontarien de la qualité des services de santé, édictant une nouvelle loi relative à l'accessibilité aux services de santé et abrogeant la Loi sur l'accessibilité aux services de santé, prévoyant l'imputabilité du secteur des services de santé et modifiant la Loi sur l'assurance-santé.

The Chair (Mr Kevin Daniel Flynn): We're a few minutes after 10, ladies and gentlemen, if we can call to order again. I bring to the members' attention that you have an interim version of the summary of the witness recommendations before you this morning prepared by Ms Luski. It brings us, I think, up to Friday.

Ms Lorraine Luski: Thursday.

The Chair: I'm sorry, Thursday of last week.

**COLLEGE OF PHYSICIANS AND
SURGEONS OF ONTARIO**

The Chair: Our first delegation this morning is from the College of Physicians and Surgeons of Ontario. If the three delegates would come forward and make themselves comfortable, I'll just briefly explain the rules to you. You have 20 minutes to use any way you see fit. At the end of your presentation we'll take the time remaining and share it proportionately with the three parties represented here this morning. It would be appreciated if you would introduce yourself before you speak, for Hansard. I've got 10:04 and the floor is yours.

Dr Barry Adams: Thank you, Mr Chair and members of the committee. On behalf of the College of Physicians and Surgeons of Ontario, I'd like to thank you for this opportunity to make this presentation to the committee.

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

**COMITÉ PERMANENT DE LA JUSTICE
ET DES AFFAIRES SOCIALES**

Mardi 24 février 2004

I'm Barry Adams, the president of the college. I'm a practising pediatrician in Ottawa and I have done that for almost 40 years now. On my left is Dr Rocco Gerace. Previously he was an emergency physician in London, Ontario, and is now registrar of the college. On my right is Louise Verity, director of government relations and communications for the college.

The college governs the practice of medicine in Ontario in keeping with the overarching principle of the legislation that guides us, the Regulated Health Professions Act. The principle is "to serve and protect the public interest." The college's duties, in part, are issuing certificates of registration which permit physicians to practise medicine and ensuring the continuing quality of physician practice through peer assessments, education and remediation. We investigate public complaints about doctors, we address concerns about physicians who may be incapacitated and we discipline those who commit acts of professional misconduct or who are incompetent.

We congratulate this government for its commitment to ensuring the best quality of health care for the people of the province. The mission of our college is the best quality care for the people of Ontario by the doctors of Ontario. Therefore, I think both the government and our college are on the same wavelength. The principles of accessibility, accountability and collaboration are central to our strategic plan.

In bringing our views on the review of Bill 8 to this committee, we look at the regulatory perspective, and more importantly, the public interest perspective as encompassed in the bill.

We'd like to convey our support for the government's decision to conduct public hearings early in the legislative process. We feel this will be beneficial because we are concerned that some aspects of the bill will not meet the government's objectives. The minister has made a commitment to revise the bill significantly. We support many of the proposed changes that we've heard and look forward to continuing to work with all parties to achieve a common goal.

Our review of the bill is organized into five key areas: self-regulation, the Ontario Health Quality Council, health care resources and access, accountability, and regulation-making authority. For a detailed summary of our analysis and recommendations, please see our full submission and accompanying table.

As pertains to self-regulation: The government of Ontario has consistently supported this principle. Self-

regulation, also known as professionally led regulation, is based on the premise that where a very specific or technical body of knowledge is needed to assess a professional's behaviour, a central role in regulation must be played by the profession itself. This duty is given to the profession with the acknowledgement that the regulator must never put the profession's interest before that of the public. The college believes that self-regulation is the cornerstone of providing medical care that is responsive and sensitive to the public interest.

With respect to block fees in the bill, we understand from remarks the minister has made and subsequent meetings and discussions with ministry staff that the government does not intend to move the responsibility of regulating block fees from our college to the government. We are pleased that this is the case. Block fees are currently a part of our regulatory responsibility. We regulate block fees by ensuring that all physicians in Ontario are aware of our policy and require that any charges for uninsured services be reasonable. Patients—the Ontario public—must be given an opportunity to make an informed choice as to whether they wish to pay for services through a block fee or on a fee-for-service basis.

As you may be aware, we are currently reviewing our block fee policy. This policy, like all of our policies, is reviewed every three years. This regular review process ensures that our policies are current and meet societal and professional standards. As part of the review of our block fee policy, we will consult with all stakeholders. This consultation will include input from government, the public and the profession. An important component of this process is to ensure that new or revised policies are clearly communicated to the public and the profession.

We believe that this section of the bill should be eliminated. The legislation as currently drafted would establish a regulation to govern block fees. Currently, the block fee policy is not enshrined in regulation. This is our preference, as it allows us to review and change the policy in a timely way. We welcome your suggestions about improving the block fee policy.

We support the Ontario Health Quality Council, but we believe the council's policy objectives, as well as its functions and duties, should be set out in the legislation as opposed to being left to regulation. For example, section 4 includes as a function of the council the support of "continuous quality improvement." This is currently a mandate of the health professional colleges under the act. We are supportive of any initiative that would guarantee quality health care to the citizens of Ontario. However, we are unsure as to where the responsibilities of the college might end and those of the council may begin.

Given that health regulatory colleges are responsible to the public interest and that they have a legislated duty to develop and carry out quality assurance programs, we wonder why this group is to be excluded from membership on the council. It is our hope that at the very least a strong and effective advisory structure to the council will be established. We would be pleased to help identify candidates for the council, as well as advisers to the advisory committee.

1010

Health care resources and accessibility: In this area, the college is committed to working in partnership with government to find ways to make health services more accessible. We know we share this goal but we suggest that this part of the bill may have some unintended consequences to the contrary effect.

With respect to section 15 of the bill, we understand that the intent is to prevent queue-jumping by punishing those who pay or accept a benefit for moving up the queue. Queue-jumping is not the problem, but rather is a symptom of long waiting times. This provision in the bill focuses on the wrong issue. Queue-jumping only happens when there are queues. Many patients in this province are waiting for health care services. They are in pain, partially or fully debilitated, and may through no fault of their own have months and sometimes years of waiting in front of them. Let's work together to fix the system, rather than just address the symptom.

Years ago, when there were long queues for cardiac surgery and people died while waiting for their surgery, the government instituted a system whereby people would be put on lists according to their needs. If the service couldn't be provided in Ottawa but a space was available in London or Toronto, these patients would have the option of moving into those spaces and having their surgery earlier. I think the same thing could be done for hips and knees and the other areas where there are patients waiting for years to have the services done.

Accountability is a critical component of our health care system, and we are supportive of an accountability framework. The accountability proposed in Bill 8 is focused in one direction: from health providers to the government. We believe that just as health providers must be held accountable, so too must health care consumers and government.

This part of the bill gives power to the Ministry of Health to establish accountability agreements. Although drafted with the right intention, we are concerned that the provisions of this section are heavy-handed and have the potential to interfere with care. The college recognizes that the minister has made a commitment to negotiate agreements with hospital boards rather than impose such agreements upon them. We believe this approach is much more appropriate.

As to regulation, I'd like to speak briefly about the extensive regulation-making authority set out in the bill. As a result of this authority, it is very difficult to analyze the practical application of the bill. We understand the minister has indicated that he intends, through amendments, to beef up certain sections of the legislation rather than leave them to regulation. We support this move. Furthermore, we understand that the government has agreed to consider a 60-day consultation period for development of regulations. This, in our view, would be a very constructive approach if the consultation is broad in scope.

Thank you again for the opportunity to appear before this committee. The college and the government share a

common goal: providing the best quality of care for the people of Ontario. We hope our analysis of the legislation will be helpful to you as you move to the clause-by-clause deliberation stage of the bill. The legislation must be significantly amended. We welcome the opportunity to continue to work with government as amendments are developed and finalized.

Thank you for hearing us. We'd be pleased to answer any questions.

The Chair: That's great, Dr Adams. Thank you very much. You've used up about 11 minutes, which leaves us with nine. So we'll assign three minutes to each of the parties, starting with Mr Klees.

Mr Frank Klees (Oak Ridges): Thank you, Dr Adams, for your presentation. We've now completed almost a week and a half, I suppose, of hearings on this bill, and I have to say to you that we have yet to hear from any group that supports this bill. In fact, the minister himself, when he presented here at the opening of these hearings, was very apologetic for what he admitted was a very flawed piece of legislation, and undertook that there would be wholesale revisions and amendments to this bill.

You've effectively pointed out a number of areas of your concern. I'd like to follow up in one specific area, and that's related to block fees. I gather from your submission this morning that the minister has specifically undertaken to you that the regulation of block fees will be left with the College of Physicians and Surgeons. Can you confirm that for us, for the committee, this morning?

Dr Adams: I have to pass to Louise, as she has been in discussion with the ministry staff.

Ms Louise Verity: On that particular point, we have had a number of discussions with staff at the ministry, and we understand that the intention is not for the government to take over responsibility for the regulation of block fees. The discussions we've been having are really around how we can perhaps amend the bill. But I think the government's also looking for an assurance that the policy—and this is one policy that Dr Adams has mentioned we are currently reviewing—is not only strong and effective, and responds to the public need, but also that it's well communicated. That's an area that we have committed to also discussing with government. As a matter of course, any time college policy is reviewed, there is certainly discussion with government as well.

Mr Klees: I can tell you that there's very broad concern across the province from physicians, the way this legislation is written, that in fact block fees may well not be allowed, certainly not allowed the way they are now, because if the government was satisfied that all was well, this wouldn't be here, would it? Frankly, we don't trust a great deal of what the minister or this government is saying; they haven't done a very good job of keeping their promises, and we asked him to get to us in writing the areas where they're prepared to make some amendments. Interesting enough, section 16 wasn't one of them.

I say to you that if you're relying on the minister to work these things out in regulation, be very, very sure of

what you believe the minister is telling you today. Certainly, we will be insisting that any regulations come forward to this committee for our review to ensure that in fact what the undertaking has been in the course of these hearings is reflected in those regulations.

Mr Rosario Marchese (Trinity-Spadina): Thank you, Dr Adams and Dr Gerace, for being here. I have a couple of things. This bill reminds me a bit of the old Conservative omnibus Bill 26, which had tremendous powers that it had given to itself, including introducing eight municipal bills, each one building on the errors of the first and lack of proper consultation. I don't expect you to comment on that, really, but do you think this Bill 8 was perhaps introduced with some haste—not consulting with some of the stakeholders wisely or properly? Just an opinion.

Dr Adams: I don't know if it was introduced with haste, but we know it was introduced with the intention of having wide consultation before going to third reading. We certainly appreciate that the government has asked for that consultation early rather than later.

Mr Marchese: Very well.

On the block funding, you review it every three years. In between, presumably you find abuses. How do you deal with that? Is it public? Do you deal with it expeditiously? Does the example that you deal with help the others not to perhaps continue with some of those abuses? How do you deal with that, in between?

Dr Adams: Probably the registrar can answer that more, but we do deal with it in a couple of ways.

Dr Rocco Gerace: There's a range of responses that we have. In the vast majority of cases, there are simply questions raised by either a physician or a member of the public. We educate them, and generally in that forum both parties are quite happy that it's been explained and we're comfortable that the policy is being followed.

1020

That being one end of the spectrum, the other end of the spectrum is a discipline hearing that was conducted—I don't remember exactly when—where a physician was simply behaving in an egregious fashion with respect to fees. A disciplinary hearing was held and he was found guilty of misconduct.

Mr Marchese: That worries me. I heard two examples that were given yesterday of two doctors charging \$1,200, I think it was, of block funding. I'm not sure I've got the facts straight, but those were two kinds of instances that were offered. One worries about that kind of fee. Maybe some of those fees should be covered by OHIP, I don't know. While some of those are legitimate, you simply wonder about that kind of fee. If the college isn't dealing with it in a way that satisfies governments, in a way that is satisfactory, governments then say, "Maybe we should be regulating it."

Dr Gerace: We've not been told, leading up to the introduction of this bill, that we hadn't been managing it properly. I think if we had had concerns brought to us with respect to how we deal with our block fee policy, we would have addressed them. We deal with it on a

regular basis, and while we can't talk about cases currently being investigated because of the privacy provisions of the legislation, I can tell you that whenever a concern is brought to us, we will address it.

Ms Kathleen O. Wynne (Don Valley West): Thank you very much for coming here today and for acknowledging the process of consulting early on a bill. As you know, this is after first reading. There will be another opportunity after second reading to give input. I don't expect my friend across the way to understand consultation, because that's not how they ran government. So I do appreciate your acknowledging that this is a good process.

I want to ask about the review process around block fees. Who does a patient contact if they have a complaint regarding the appropriateness of a block fee? Who do they get in touch with?

Dr Adams: They get in touch with the college. We have intake workers who register the complaint and it then goes to the complaints committee. Or some of them are resolved just by discussion with the patient and the doctor and it can be resolved in that area. If not, it goes to the complaints committee.

Ms Wynne: So it's a complaint-driven process.

Dr Adams: It's a complaint-driven process.

Ms Wynne: OK. This review that you are undertaking, how is the review going to address the issues of better informing the public? I think one of the concerns about block fees is that it's a bit of a grey area for people. It's handled differently depending on where you are. I think what we're trying to get at is, how does this become a more open process? They exist, and they exist for all sorts of reasons that we could go into, but how is your review process going to deal with the transparency issue for patients?

Dr Gerace: With respect to all of our reviews, we will consult as widely as necessary to get as broad an input as we can to revise any policy en route to counsel. If there is a perception that patients are being hard done by, we can consult with patient groups, and we've done that in the past for some of our policies. I'm not sure anyone has told us that this policy is broken. I welcome input from all stakeholders to suggest that there are problems that are not being dealt with. We will consult with patients, we will consult with doctors, we will consult with government, we will consult with others who have a stake in this issue.

Ms Wynne: So there's a bit of a disconnect, because we have heard people come and say there is a problem with this, so we obviously need to continue talking about this.

The Chair: The time has expired. Thank you, Doctors, and Ms Verity. Your presence was appreciated here this morning.

NORTHUMBERLAND HILLS HOSPITAL

The Chair: I'd like to now call forward the delegation from Northumberland Hills Hospital, which had been a

delegation of one but I understand now it has swollen—grown—a little bit. Greetings. Make yourselves comfortable. The same rules as the previous delegation: You have 20 minutes to use any way you see fit. At the end of your presentation we'll apportion that time as equally as we can among the three parties, starting this time with Mr Marchese. Would you introduce yourselves for Hansard, seeing as there are five of you. I've got 10:27 and the floor is yours.

Mr Don Morrison: I'm Don Morrison, chair of the Northumberland Hills Hospital. On my left are two of our board members, Bob McInnes from Port Hope and George Bonar from Cobourg. On my right is our CEO, Joan Ross, and on her right is Peter Delanty, our mayor in Cobourg. We're delighted to make this presentation to you this morning. I'm making the formal presentation here because our concern about this bill is concentrated in the governance area. That's what we'd like to concentrate our remarks on in the limited time available.

Let me give you a quick description so you'll understand where our hospital is coming from. We operate in the 401 corridor, between Oshawa and Belleville. Our hospital is the biggest hospital. It covers a 50-mile space down the 401 corridor, on the north shore of Lake Ontario. This area is growing at the provincial average, even though it's a largely rural setting. The area around Cobourg is actually growing considerably faster than that. With the movement out of the GTA, that certainly is expected to continue. We also have the fourth oldest population of catchment areas in Ontario, which causes us particular concern. The bottom line is, health care, which tops every election poll that you're so familiar with, is certainly the top priority in our community.

Five years ago, our board inherited one of the worst messes in Ontario. There had been a long-standing conflict between the two smaller hospital communities in Port Hope and Cobourg, which reached a point where the Port Hope hospital was ordered closed by the HSRC. The board of the hospital was essentially hijacked by the embittered Port Hope community, and as a result ultimately the HSRC dismissed the old board. It became necessary to appoint a new board, which was done through a community nominating committee, and we believe we're the only board that has a ward system to ensure that there is democratic representation by area. That became necessary to resolve that and that's the framework we inherited.

The board also inherited a position that the HSRC had mandated, a \$17-million renovation of the old Cobourg site. The Port Hope hospital was ordered closed and we had to sell it. That was one of our first duties. The \$17-million renovation frankly was completely inappropriate. We could not have funded that and we quickly proved that it would cost as much to do that properly, with the enlarged program that had been approved, as it would to build a new greenfield site. We had to make that case and we had to sell it to the community, which we did.

We've come a long way since that period. What we essentially did, in order, was that we had to dispose of the

Port Hope hospital, with all the turmoil that focused on and the community criticism from that part of the population, and we had to develop the case for the new green-field hospital. What we did at the end of the day, with all of the work down the line in terms of selecting the site, redeveloping it, getting through the municipal approvals, raising the money, was that we built a \$75-million, spanking new hospital that opened last October. It's been operating for three months now.

The result of all this has been simply an incredible success. We have raised \$24 million in the community, including \$6 million from the municipalities and an \$18-million fundraising campaign. That amounts to over \$450 per capita—I'm talking about public fundraising only, not the municipal money—which is what our residents have contributed to this hospital on average. It shows how much they value health care and what it means to them. With a good program, they endorsed it, they hopped on, and it has been completed. It was completed on time, on budget, but I can tell you it took a lot to get there.

Throughout the period, this was an incredible combination of teamwork from our great staff, our CEO, the planning team, the consultancy architects we used, but it was the community that made this happen and it was the board that led that. It could not have happened without the combination, but it was the board that sold the vision. We designed, for example, the financial plan, which was completed, as I say, on time and on budget. I think it is a textbook success in terms of how the system can work if it works properly, and that we did.

1030

The community acceptance and enthusiasm for this is such that we had 10,000 people tour the hospital in the first two days of our official opening weekend. It was just a happening, it was incredible. The enthusiasm for the services since has also been great.

One of the great concerns we had with the old hospital, being subject to the two smaller ones being divided, frankly, our services fell through the cracks. We didn't have the total service that we were entitled to and that is justified by the new central community hospital. It's in the right location, in the centre of the area, and it provides the services that we need to operate properly.

What we've accomplished now is to get us back to about where we should have been in terms of equity compared with other provincial peers. We have not got a Taj Mahal, as some people have said. It's not excessive. We ran a very Spartan operation, which is why we're on time and on budget. I think, if you know hospital construction, that's a pretty unusual event in both cases.

In any event, unfortunately for us, we opened the hospital a month before Bill 8 was introduced. We see it as a very serious threat. Bluntly, we do not think, as a board, that we could have accomplished what we have under this structure. We think that the attitude in Bill 8, above all, is very unfortunate, very destructive and unwarranted. We're very concerned about the mentality that permeates the whole legislation.

The most shocking thing about it is that it was introduced without any consultation. It's fine that we're having these opportunities to appear as we are today, but this is very late in the day. There are only a couple of weeks of scheduled hearings. We haven't got the details of the amendments. We haven't got the regulations. We don't really know what this means. Above all, I'd encourage the committee to extend the process so that we can see what we're looking at before this is finalized. I'm assured by the comment that we may have other opportunities at second-reading level.

Bluntly, in the interest of brevity, we see Bill 8 as a transparent attempt by certain bureaucrats to take over control and centralize the hospital system. It's very clear what the intent is. We think there's going to be a very substantial policy movement to increased regulation, amalgamation. At the end of the day, what that has meant previously is reduction of hospital services, not an increase.

We recognize there's a very serious fiscal problem, but we've always represented our community and we've done the right thing. We don't think we've been unreasonable or that we've asked for things that we're not entitled to. We know, because of the fiscal situation, that obviously we're all going to have to cut our cloth accordingly, but to have the kind of structure we're looking at now is simply very destructive of the whole system and the relationship that we must operate in. We frankly see a parallel to the consolidation of school boards that the previous government introduced, which I don't think most people feel has been successful. It has certainly been very destructive in communities like ours.

Our community wants to participate. We have thousands of people involved in this process in one way or another. We have an auxiliary that has over 500 men and women in it. It has increased by 25% in the last year. They come from over the whole catchment area. That's what it means to run something like this. They are there from 7 in the morning until 7 at night as volunteers to make this hospital work as well as it could.

We're of the view—and we've looked at the regionalization theme very thoroughly. There have been seminars and hospital circles. We have never, frankly, seen any documented evidence that regionalization is cost-effective. The bottom line on it, I think, is that it has done a lot of damage, it has caused a lot of upheaval, and I don't think it has improved the system. We would not like to see that direction followed, and I'll talk in a moment about more constructive directions in which we think we could go.

We note, for example, particularly in terms of the section of the bill that the minister seems determined to maintain—I think it's 26—that the CEO would report to the ministry as well as to the board and could be terminated unilaterally without any compensation. We see that as particularly destructive. We have a very fine relationship. The CEO is our only employee. That is an intolerable way to operate. The board would essentially be gutted in terms of its authority. The CEO would

always be looking down the rifle barrel and wondering where he or she should report. That's an ambiguity that the BC government and the auditor concluded was completely untenable and made strong recommendations about. I point that out because some of the models of this proposal seem to be taking after the BC system as a model.

On the other side of it, I point out that the title of the bill in itself is misleading. To term this thing a commitment to the future of medicare is simply deceitful. This does very little to improve medicare. As I've already said, it clearly threatens and destroys some of the things that are important to making it work. Much is made of the need for increased accountability on the parts of boards. Frankly, I've run major businesses, and I think there's all the authority and accountability in the present system that should be required to make this work properly. The minister has the powers to introduce an inspector, an investigator and, finally, a supervisor, which is like a trustee in bankruptcy. The board can be terminated at any time. You've got budget control. You've got funding approval for the dominant portion of our operation. There's moral suasion. There are all the stops along that way. Why should there be a need to single out and make such a major issue and, above all, a merit of accountability?

I heard this morning that it was news that hospitals are going to be accountable and forced to reduce waiting lists. Well, you've got to get there. We need funding and we need to be able to do that. This bill does nothing like that. It threatens our doctors. You heard something of that in the earlier presentation. That is a very fragile situation and that's been severely disturbed by the mentality in this bill to date.

We think there is a great deal of accountability. Not least, I point out to you that under the Public Hospitals Act all hospital board members are personally liable for what they do. That was always enough discipline for me, I can tell you. Our board worried long and hard about the major decisions we had to make, the risks we had to take. At the end of the day, there'd be no doubt, if it went wrong, who was responsible. I think that is the greatest guarantee you can have of good discipline, but we all know there have been other methods. What I'm saying is that, through a combination of good management in the ministry and working closely with the hospitals, I think the system can be made to work. Again, I think what we've accomplished has been exemplary, while it certainly hasn't been without difficulty and has required an awful lot of relationships and conversations to make work.

Constructively, what we'd like to see focused on, rather than the brutal risk of amalgamation, centralization, regionalization of hospitals run out of Queen's Park, is the communities. That dimension very much concerns us. We think we understand the local needs and we think we're sensitive to taxpayers' interests as well. We'd like to see concentration on so-called vertical integration. There is not enough linkage between the access centres,

the long-term care centres, the medical clinics and other things that total the health care system. The hospitals wind up being the dumping grounds for things that happen in those organizations that we can't do anything about. It's a myth that there is very simple and easily negotiated accountability of the sort that I think is intended here. Frankly, that intention is naive. We don't control when doctors write medical orders to admit patients to hospital beds or to get X-rays or whatever. That has to be brought into the equation here. We can't control what happens to long-term-care beds—they're over the fence—but when there aren't enough of them, they back up and our hospital beds are full. When a doctor goes on holidays or after-hours, the recording, as any of you must know, is, "Go to your nearest emergency ward." Guess what that does to us in terms of controllability? Probably 80% of our emergency patients aren't really emergencies. They're there because there are no doctors and because their doctors aren't available. That, in terms of controllability and accountability, is very important.

If accountability is to be further strengthened, such agreements have to be very sensitive to these kinds of issues. Above all, they have to be discussed and mutually understood. Otherwise, you are just going to pass in the dark all over again. As our new hospital project has shown, a lot can be improved in the present system. We struggled with the silos in capital projects. You have to deal with one group for your bricks-and-mortar building, then you have to have another whole round with the equipment people. You're uncertain, and there are very fuzzy rules, as to what happens in terms of the transitional costs in terms of training and moving. The last thing you do is get approval for your post-construction operating budget. When I had to explain that to Lou Rinaldi, he couldn't believe it. He said you never should have started the hospital. It's impossible, and business people would have thought it was. Here, it's the way things operate.

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There's a lot that can be improved in this system. What we're worried about is that, while we've succeeded, there's \$8 billion, as I understand it, of capital planning going on for other hospital projects. If this isn't well-thought-out and processed more efficiently, a lot of money is going to be wasted, because there's high risk of disasters in that structure. At the same time, if you turn off the community input and enthusiasm that we've enjoyed, you're not going to be able to collect the pledges on the existing campaigns that are out there. If we have a centralized service and let's say our obstetrical work goes to Peterborough or somewhere else, is somebody going to pay for their last tranche of the pledge? Not likely. What about the new hospitals? If you're talking \$8 billion, you're talking from a third to 50% that has to be funded through the community or some other way. That's a lot of money, and it's not going to come under this kind of structure.

Frankly, if this bill were to go through, our board has already decided that it would resign and it would not

participate. That's how strongly we feel about it. We think this bill should be sent back to the drawing board, that full upfront consultation should occur. We'd be delighted to participate in it. We'd be delighted to be made accountable, but this bill does not solve our problems.

The Chair: Thank you, Mr Morrison. We've got about three minutes left. So let's start with Ms Martel.

Ms Shelley Martel (Nickel Belt): I very much appreciated your comments. You're right: The bill is very destructive. The powers are quite overwhelming, and the problem is that it doesn't look like there's going to be any change, despite what others may tell you.

Before you leave, you want to get a copy of a February 19 letter that the minister gave to this committee in Windsor last week outlining the changes that he intends to make as a result of concerns. I want to tell you that there aren't changes that are going to meet with your approval, because it's very clear in section 22 that the minister will still have the power to issue a compliance directive or an order. So at the end of the day, the minister can still drive it home with a sledgehammer.

Secondly, under section 23, the minister still has the power to deal with CEO compensation or any other financial remedies to be applied to a CEO as a last resort after due process, blah, blah, blah. So I don't think your concerns with the current bill are unfounded, and frankly, your concerns should still be much in existence with the proposed changes that the minister has put forward, because at the end of the day, the minister is still going to continue to have broad, sweeping powers. There's no mention of negotiation, and the minister still has the control at the end of the day with respect to compliance directives and orders.

Given that that is very clearly the case in terms of the direction, do you feel any differently in terms of what your board intends to do?

Mr Morrison: No, absolutely not. Frankly, the Ontario Hospital Association has been far too passive about this until recently, because they were optimistic that the minister's promise to make changes would occur. I think those of you who saw the presentation yesterday will know that they're certainly very critical and uncomfortable with the current state of those amendments. We don't find them satisfying at all. My comment was written with those amendments in mind.

Ms Martel: Very good.

The Chair: Thank you, Mr Morrison. Ms Wynne?

Ms Wynne: Actually, Mr Duguid is going to ask a question.

Mr Brad Duguid (Scarborough Centre): Just very quickly, because there's not much time left at this point. I served on a hospital board for nine years, up until last year, and I've got to tell you, if I thought this legislation was going to do anything to, as you say, gut hospital boards, I'd have concerns about it. It will not gut hospital boards in any way. Hospital boards will have to be accountable to government, and hospital boards that I know and members of hospital boards whom I know want to be accountable for what they're doing.

So I'm really concerned about comments like, "We're going to resign if this bill passes," or that somehow hospital boards are being gutted by this bill when, as you recognize, the Public Hospitals Act gives the government the only tool that they have right now when there is a rogue board or a rogue CEO to move in and put a supervisor in.

What this bill will do is give you some interim measures that we can take and a process that will be set up in the regulations and through the accountability agreements so that we don't have to go to that length, so that there are things we can do to work with the boards rather than just taking them over. The previous government, and probably rightfully so on a couple of occasions that I'm aware of, had to use those powers. Those are extreme powers, much more extreme than what we're talking about in this bill. So I'm curious as to why you would think this is in any way gutting the boards.

Mr Morrison: I've been on a lot of boards of directors, and there is no jurisdiction I know of where the CEO reports in two directions at the same time.

Mr Duguid: There's nothing in this bill that says the CEO reports to the government.

Mr Morrison: Essentially, if the CEO can be terminated without notice and without compensation, you've got all the power you want. We would worry about who the CEO looks to.

The Chair: Thank you, Mr Morrison and Mr Duguid. Our time has expired. Very, very briefly, Mr Klees or Ms Witmer.

Mr Klees: The fact is, if I was in your shoes, I would resign too. Don't believe—

Ms Wynne: Why don't you?

Mr Klees: —this minister. Because I'm not in their position. The fact is that this bill will do exactly what you say it will do. It puts all of the authority, all of the power, into the hands of the minister. As Ms Martel indicated, the indications we've had from the minister that they are going to make substantive changes—the letter proves that they have no intention of doing that whatsoever.

This is heavy-handed. It is draconian. There is an absolute disconnect between what the preamble, in lofty language, says it's going to do and the rest of the bill. That's why we've been calling on this government to scrap the bill and start over.

I can say to you that either the minister did not understand this bill when he read it before it was tabled with this committee or he didn't read it, because no one in their right mind would bring forward a bill that attacks every sector of the health care community in this province, every sector. You're not alone. We heard from unions. We heard from doctors who say they are going to leave the province if this bill goes through. We heard from nurses. We heard from the volunteer sector. There isn't a single sector in the health care field that believes there is anything in this bill that is productive and that will help health care.

The Chair: Thank you, Mr Morrison. We do appreciate your frankness and your input today.

**ONTARIO PHYSIOTHERAPY
ASSOCIATION**

The Chair: I now call forward the delegation from the Ontario Physiotherapy Association, Signe Holstein and Caroline Gill.

Ms Signe Holstein: It's just Signe Holstein, due to traffic. I apologize to the committee.

The Chair: The last delegation grew; yours has shrunk. Same rules: You've got 20 minutes. You can use that any way you like. Any time that is left over will be split among the three parties, starting this time with the government side. If you would introduce yourself for Hansard, I'd appreciate it, and the time is 10:49.

Ms Holstein: Thank you. My name is Signe Holstein. I'm the chief executive officer for the Ontario Physiotherapy Association. Our president, Caroline Gill, who works in multiple sectors that could be affected by this bill, wanted to be with us today but is somewhere in traffic.

There are about 6,000 registered physiotherapists practising in Ontario today, and the Ontario Physiotherapy Association represents approximately 4,300 of those, or about 70%. On behalf of the entire membership across Ontario, we look forward to working collaboratively with this government to address some very serious challenges that face the health care sector which in our view are largely the result of misguided policies and chronic underfunding in our sector.

We decided to organize this presentation into five segments, each of which relates to specific provisions in the bill, some of which we strongly support, some where we suspect some oversight and some where we have major reservations. We are aware that the Minister of Health and Long-Term Care will be submitting to you a number of amendments that will address some of these concerns that we will be mentioning today. This is encouraging. However, we are not aware of the exact details and, as such, we can only comment as it is currently written.

Let me begin by saying that we appreciate the central thrust of accountability as one of the specific provisions of this bill.

Over the last five years or so, a number of publicly funded hospitals in Ontario have created within their precincts private rehabilitation clinics. By "private rehabilitation clinics," we mean clinics that offer services to the public for which either the patients pay directly or the costs are covered by extended health or other third party insurers. Put another way, these clinics do not bill through the government plan or through OHIP, whether in whole or part, for any part of that treatment; they bill privately.

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We don't know exactly how many hospitals currently operate such clinics. We suspect, from anecdotal evidence, that somewhere around 22 hospitals are doing so. Many of the hospitals that set up these clinics have tried to obscure their relationship with the clinics for reasons

that I will relate. Some hospitals as well have decided recently to load-shed physiotherapy services by simply closing down their ambulatory care clinics for the same reason.

Rhetoric aside, the principal objective of the private clinics is to generate revenue to cross-subsidize the publicly funded operations of the hospitals. This is deemed necessary to offset inadequate government funding. In this respect, we are very sympathetic to the hospitals' plight. What the OPA takes issue with is the solution.

Physiotherapy, when provided in hospitals, is an insured service under the Canada Health Act. Accordingly, we believe it axiomatic that when a hospital provides physiotherapy services, it must do so within the publicly funded system. When physiotherapy services are provided by hospitals in privately funded clinics, we think this is a clear infringement of the Canada Health Act, but as I am sure many of you know who have looked at the Canada Health Act in terms of interpretation, it's very open to interpretation.

Furthermore, people are attracted to private rehabilitation clinics in hospitals because they can get faster treatment or because they think they can get a higher quality of care. This is the epitome of two-tier health care.

Finally, the existence of private clinics in public hospitals, from any of the evidence that we have been able to gather, has not reduced waiting lists for publicly funded services. In fact, it may actually have created a net reduction in rehabilitation services because some hospitals have shifted resources from the publicly funded rehabilitation clinics to the privately funded ones. A member of our association has been involved in a PhD study over the past two years trying to get better data on what is actually happening in the sector.

The OPA has raised this issue with the Ministry of Health and with successive Ministers of Health since late 1996, but no action has resulted. Bill 8 may provide some of the tools to address the problem.

The second issue we would like to address relates to section 10. We would ask whether physiotherapy was left off the list in error. If not in error, what is the reason for excluding physiotherapy? We have asked that question of the ministry but have received no answer. OHIP covers physiotherapy services provided by approximately 100 facilities and individual practitioners registered under OHIP schedule 5, and there is a fee schedule, negotiated with the ministry, which applies to the services rendered. As such, it is incomprehensible to us why physiotherapy should not be listed.

Our third issue relates to those sections of the bill relating to the collection, use and disclosure of personal health information; for example, sections 13, 14 and 29.

To avoid confusion and to reduce costs of implementation and enforcement, we think there must be a single regime for the protection of personal health information in Ontario. The OPA has supported the regime set out in Bill 31 that is currently being considered. We think

that Bill 31 should have primacy across all provincial legislation and that provisions relating to the collection, use and disclosure of personal health information should be made consistent with and subject to the provisions of Bill 31.

We are, as well, concerned about the prohibition against block fees in section 16. The prohibition would apparently apply to fees that are charged for health services that are not insured services as defined in section 1 of the Health Insurance Act. As committee members may know, there is a move toward block fees in several payer streams. Although we may take issue with the monetary value of some of the block fees—it's our job—the OPA very much supports the concept. Why? Because block fees give maximum discretion to the practitioner to provide the number and type of treatments that the practitioner believes each patient requires; because block fees keep insurers out of the micromanagement of treatment; because block fees reduce administrative costs; and because block fees can be used to emphasize prevention.

In the workplace safety and insurance stream, the WSIB hopes to have as many as 80% of WSIB-funded treatments provided through programs of care for which practitioners receive block fees. The OPA and several other health care associations have been deeply engaged in the development of the programs of care and the associated fees. The level of employer, employee and practitioner satisfaction is very high, and we are confident that this approach will result in better care at a reasonable cost. Accordingly, we are very opposed to any legislative prohibition against block fees outside the publicly funded system or that may be interpreted to impact on that.

Our biggest concern, however, relates to part III of the bill. The provisions of part III, to our mind, are very draconian and one-sided. The minister shall decide when, with whom or what he will enter into an accountability agreement. The minister may unilaterally terminate or vary an accountability agreement at will, with no provision for notice. An accountability agreement entered into with one person automatically applies to that person's successor. Where an accountability agreement results in a material change in a person's terms of employment, "The change shall be deemed to have been mutually agreed upon between the person and his or her employer and the change does not entitle the person to any sort of payment or compensation, despite any provision to the contrary, in his or her personal contract or agreement of employment," and the crown is relieved of any liability for anything done as a consequence of the accountability agreement.

From our perspective, in one fell swoop the Employment Standards Act and labour law in general, collective agreements and individual employment agreements are swept aside. It's breathtakingly heavy-handed and, with greatest respect, not particularly becoming of a Liberal government.

The final issue we would like to raise relates to part IV, amendments to the Health Insurance Act. Professions

such as physiotherapy, medicine, optometry and dentistry negotiate their respective OHIP fees with the Ministry of Health and Long-Term Care. At the end of the day, however, it is accepted that the ministry negotiates only as a courtesy and may impose any fee it chooses. Subsection 40(2.1), which allows the minister to unilaterally amend a schedule of fees in whatever manner he deems appropriate, would be harsh enough in its own right. In light of the foregoing, it is not only harsh; it is unnecessary.

One of the OPA's priority objectives is to enhance access to publicly funded physiotherapy services across Ontario. We are further away from that objective than we were a decade ago. In 1990 or thereabouts, over 80% of physiotherapists were employed in the publicly funded system. Today that figure is less than 40%. The fact is that the publicly funded system has become increasingly unattractive as an employment venue and, where practitioners have the choice, they vote with their feet in favour of the privately funded system. The impact on access to publicly funded physiotherapy is obvious.

Provisions such as those relating to the accountability agreements and a unilateral amendment of OHIP fee schedules may be well-meaning, but they will have the contraindicated results of making the publicly funded system less attractive, thereby encouraging practitioner exodus to the privately funded system in direct opposition to what we want to achieve. Accordingly, we beg you to reconsider these provisions. They hurt us more than they can help.

Thank you for your attention. We would be pleased to answer any questions.

The Chair: Thank you very much. There are about nine minutes left, so each party will have three minutes. We'll go to the Liberal side first.

Ms Wynne: Thank you for coming down today to talk to us. I just want to address a couple of your issues, and then I have a question for you.

First of all, under section 10 you noted that physiotherapists are not listed. There are a number of organizations that are not. That wording has been lifted verbatim from other legislation. If you look at subsection 10(3), you'll see that you, the chiropractors and a bunch of other organizations are captured. So there's nothing there that would limit the ministry from dealing with your organization. I just wanted to make that clear.

1100

The other thing I wanted to acknowledge is that you've identified some sections—and I hope you'll pick up a copy of the framework of the amendments, which are not in their final form but that we're proposing to put forward. Just about every section you've named is an area where there's going to be amendment, specifically around accountability in part III, the accountability issue. We understand there needs to be more clarity, more specificity around what those accountability agreements will be and what the minister can and can't do. The amendments that are being proposed will address those issues, understanding that we're still in consultation and

that those things will change, which is why you don't have the final wording.

You've said that since 1990, things basically haven't been getting better. That's quite a while. I want to ask, if you were in the Minister of Health and Long-Term Care's seat, what would you do to improve accountability? There's a sense that there's a lot of money going into health care but it's not being spent in a way that's helping patients. What would you do to improve accountability?

Ms Holstein: Certainly in issues around the priorities of funding—the funding priorities have been to acute illness care; we're in the rehabilitation business. It's not that we aren't involved in acute care, from intensive care through palliative care, but the focus on continuing to fund the acute piece—we understand the rationale, but as budgets tighten, the things that are left by the wayside are rehabilitation, long-term care, wellness, prevention and health promotion. Those are all key elements of who we are and what we do.

Ms Wynne: Then I hope you'll continue to work with us, because that's exactly what we want to get at. We want to get at a shift away from institutional care and more into community-based, more into wellness-focused. That's where we want the dollars to go, but first we've got to figure out where they're going now. This bill is the first step toward that.

Ms Holstein: I would draw your attention in the future to submissions this organization has made to the primary care transition fund, because we are committed to health promotion and prevention and, within the primary care milieu, have been part of that process and have submitted projects.

Ms Wynne: Thank you. I hope the next 13 years are better than the last have been.

The Chair: We'll go to Mrs Witmer.

Mrs Elizabeth Witmer (Kitchener-Waterloo): Thank you very much for your presentation and for the services you provide to people in the province. I know they're very much appreciated.

This bill, despite what you're hearing, I believe, after hearing many presentations and reading many letters, is really a very shoddy piece of legislation. I think it's very poorly drafted. It has certainly raised the anxiety of health stakeholders, unions, health providers and individuals throughout the province of Ontario.

Many people are saying, for example, that the accountability provisions need to be totally withdrawn and rewritten. As I listen to individuals really tear apart this bill, because there was no consultation with any of the stakeholders prior to the introduction, I guess my question to you would be, what are the key amendments you need to see before your association would be able to support this bill?

Ms Holstein: I think you have to remember that most of our members in this particular sector are going to be in two places. One is they're going to be employees in hospitals. We have significant concerns about the impact of this bill on those members, particularly the account-

ability provisions. We have not seen the wording. I've received it. I haven't been able to go back through the legislation.

Mrs Witmer: The wording for?

Ms Holstein: The memo from February 19.

Mrs Witmer: The memo from February 19 is over there, and you're going to see that it will not address your concerns. There is nothing specific in there to allay any fears. We've had stakeholders in here. They've read it and don't feel comforted.

Ms Holstein: We do have concerns. When you put the kind of accountability of the CEO directly to the minister—I sit in a CEO's position, so I'm particularly sensitive to this, I suppose—it's like serving two masters. I think it's that concern, the serving of two masters, where whatever the CEO has to do to maintain that relationship may or may not be in the interests of the whole, that would be a major concern. So that is an area.

We are also very concerned—yes, the unions have spoken about some of their concerns. We also have a number of members in hospitals who are not unionized. They are professionals, not part of a unionized environment, and those protections need to be built in for them as well. They are already feeling very much under-valued, under-appreciated and overstressed. We can show you the research, and if you read the OHA human resources study, it's in there. They used our research. It's an area that concerns us terribly at this point in time: How do we ensure that physiotherapists are comfortable working in the public sector and stay in that sector? It's very necessary.

Mr Marchese: Good morning to you both. Sorry I missed much of your presentation. I had to do a conference on something else.

Ms Wynne talks about how proud she is of the consultations they have made, and presumably by the consultations they made, they mean to speak to these hearings. But normally what we mean by consultation is that before you draft a bill, you talk to people, so that by the time they come here, you find some supporters of the bill. Based on what my colleague Shelley Martel was telling me, because she is a member of this committee, most of the people coming before this committee are opposed to much of what is in this bill.

Good policy generally means that you talk to people and work some of the wrinkles out before you bring it here. Were you or anyone you are aware of consulted before this Bill 8 was brought before this committee?

Ms Holstein: Not prior to this piece of legislation, no. I would say that we're more than happy to consult on any component of physiotherapy services.

Mr Marchese: I'm sure you are. We have a new era, obviously. They love to work with people and consult. This is really great. It's very new. It would have been nice if they had started with talking to people prior to the drafting of the bill, is all I'm thinking.

The minister has talked about a particular aspect of people's concern. He says in section 19, in the definition of "health resource provider," to exclude solo physicians,

group practices and trade unions. I suspect some people might be comforted by that.

Section 22 of the bill, the compliance directives, says: "The minister may at any time issue a directive compelling a health resource provider or any other prescribed person, agency or entity to take or to refrain from taking any action that is specified in the directive or to comply with one or more of the prescribed compliance measures."

That suggests to me that there is absolute power here that's still in the hands of the minister. Does that worry you at all?

Ms Holstein: Yes. The short answer is yes. Like anything else with legislation, the devil is frequently in the details. How that's interpreted, how it rolls out in regulations, who that really means and whether or not our members are actually protected by that wording, I don't know at this point, and I would be concerned.

The Chair: Thank you, Ms Holstein, for coming today. We appreciate your input.

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OF PUBLIC EMPLOYEES,
ONTARIO DIVISION

The Chair: Our next delegation is the Canadian Union of Public Employees, Ontario Division. They are represented here today by Mr Sid Ryan, the president of CUPE Ontario, and Michael Hurley, president of the Ontario Council of Hospital Unions with CUPE. Doug Allan, I understand, is also with us as a research representative. Welcome, gentlemen, and welcome back, Mr Hurley. The floor is going to be yours in a minute. The rules are you have 20 minutes to use any way you see fit. At the expiry of the presentation, we will take any time remaining and split that among the three parties, this time starting with the official opposition. I've got 11:11 and the floor is yours.

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Mr Sid Ryan: My name is Sid Ryan. To my right is Michael Hurley, as you indicated, president of the Ontario Council of Hospital Unions and the first vice-president of CUPE Ontario, and Doug Allan, who is a researcher with CUPE National.

Just a little comment before I get into my presentation. A few moments ago a question was asked about consultation. Of course, we, the Canadian Union of Public Employees, were not consulted either. But then we only represent 50,000 members, so why would you want to talk to the people who represent 50,000 front-line workers?

We're extremely concerned about this bill. Bill 8 was released on the first anniversary of the Romanow royal commission report into health care. In his comments on the bill, Health and Long-Term Care Minister George Smitherman noted the connection, with a glowing reference to the Romanow report. He actually said to the Legislature in his speech, referring to Romanow, "His thorough review came to an irrefutable conclusion. The

pursuit of corporate profits weakens, not strengthens, health care by taking dollars and resources out of medicare." That was the minister on November 27, 2003. The Minister of Health and Long-Term Care claimed this new bill would "make universal, public medicare the law in Ontario and put an end to the creeping privatization of the system in recent years." These are clearly the themes that helped elect the Ontario Liberal government, but Bill 8 falls far, far short. In fact, it opens the door to the privatization of health care services.

The ban on queue-jumping is the professed centre-piece of the legislation, but to a large extent, this practice is already prohibited by the ban on extra-billing for insured services under the existing Health Care Accessibility Act, a bill entered into by the previous Liberal government in 1986. The bill does not, however, shut down the main threat in the Ontario public debate to universal, single-tier health care; in other words, the recently established for-profit MRI and CT clinics. Election promises notwithstanding, these corporate clinics are still in business.

P3 hospitals also threaten universal, single-tier health care through the use of their medical equipment by private, fee-paying patients in so-called off hours. Again, despite election campaign promises, instead of outlawing P3 hospitals in this legislation, the government is deepening its commitment to P3 hospitals.

The proposed Ontario Health Quality Council will not deal with many vital issues. It cannot report on the extent to which the Ontario health care system conforms with the requirements of public administration, comprehensiveness, universality and portability, key provisions of the Canada Health Act, focusing instead on accessibility. Further, the council is not required to report on two-tiered medicine, extra-billing and user fees despite the fine statements expressed in the preamble to the bill by the minister when he released the bill. The council is also specifically prohibited from making recommendations. In other words, the council cannot deal with most of the key issues that confront public health care and cannot defend public health care.

Our greatest concerns, however, relate to part III, sections 19 to 32, of the act. Specifically, we are concerned about the broad powers of the minister to require accountability agreements or to issue compliance directives.

While the government has made much of the accountability set out in the act, it is notable that the accountability in this part of the act is accountability of health care providers to the government, not accountability of the government to the public. This latter form of accountability is the sort of accountability that CUPE members and, we submit, the public really care about. Accountability to the provincial government may be an issue for the government and its top bureaucrats, but it also threatens reduced accountability to the community.

The provisions in part III have been drafted in extremely broad and general terms. They grant the minister virtually unprecedented power to require individuals

and organizations to comply with ministerial health care initiatives.

We have two related but distinct concerns about these powers. Firstly, as written, the legislation could be used by a government to try to override collective agreements. Health and Long-Term Care Minister Smitherman has recognized these are problems with the bill as written. He promised this committee on February 16 that he would introduce amendments that would make explicit that (1) the bill cannot open collective agreements and (2) that unions are not subject to accountability agreements. We tabled these amendments in Sudbury and your committee voted them down. This sends a really bad signal to CUPE and to front-line workers in all of the trade union movement that you are not being up front with us with respect to this bill. We are glad to see that the minister has recognized the bill must be amended. However, as I indicated, we remain very concerned about our collective agreements.

Prior to the election, the Liberal Party campaigned against P3 hospitals. However, the government is now attempting to implement public-private partnership hospitals in Brampton and Ottawa. The British experience with P3 hospitals shows that these hospitals are so costly that health authorities have been forced to reduce beds in P3 hospitals by 30%. Spread across Ontario, this would mean a loss of 10,000 hospital beds. This would be particularly severe as hospitals have already lost 19,000 beds between 1989 and 2003. In addition, we also note that in Britain there were 14% fewer nurses hired. This is coming from a government that says your intention is to hire an additional 8,000 nurses.

There are 38% fewer support staff and 7% fewer doctors in the UK P3 models. For just these two initial projects, hundreds and hundreds of vital hospital jobs will be privatized and well over one billion public health care dollars will be turned over to joint, for-profit, trans-national corporations. It's very hard for us to see how this puts an end to creeping privatization, as the Liberals promised, particularly as we have learned that the government has allowed six other hospitals to investigate P3s. So trust must be earned.

In BC, another Liberal government told hospital workers they had nothing to fear. When elected, they introduced legislation that ripped up collective agreements and introduced performance agreements for health care institutions. The result to date has been massive privatization of health care services and the firing of 6,000 health care workers. For-profit corporations have moved in and the new workers are paid a fraction of what the fired workers were paid. In Quebec, another Liberal government has brought in legislation that severely undermines collective bargaining in the health care sector and opens the door to privatization.

I can assure you we will not let that happen here. Be assured that CUPE members are mobilizing as we speak to ensure that our collective agreements are not opened. Our collective agreements are paramount; tens of thousands of CUPE health care members depend upon these

agreements for their families' futures. At the end of this submission we have attached, once again, the amendments we need to see to protect our collective agreements. We urge this committee to review these carefully and to ensure that the government does not miss the mark and fall short.

We do not need simple protection of our current collective agreements, as many collective agreements, including all the major hospital agreements, expire this year. We must ensure that this legislation will not open current nor future collective agreements, nor undermine upcoming negotiations.

Minister Smitherman has promised to release his amendments by March 9. We believe these should be released as soon as possible. Should the amendments not be tabled at this time, we believe the government should take the bill back to the committee following second reading to give the committee members an opportunity to review, in detail, the amendments.

Our second major concern deals with the sweeping powers this bill confers upon the Minister of Health and Long-Term Care to reorganize health care. As written, the minister can direct any "health resource provider" to enter into "accountability agreements" with the minister or with the minister and any person, agency or entity.

The minister is also empowered to issue directives compelling health resource providers and any other prescribed person, agency or entity to take any action specified in the directive or to comply with prescribed compliance measures in section 22. There is little limitation on the scope of such directives. This does not fit with the call for "negotiated accountability agreements with publicly funded health resource providers" that Minister Smitherman talked about with this committee on February 16. Indeed, this is a heavy hammer of control.

Under the bill as written, the minister's discretion is as wide as the government determines it should be. These powers could be used for health care reorganization—for example, the consolidation and privatization of laundry, lab, dietary and other services—hospital restructuring, or more privatization of health care services and facilities such as those proposed for the Royal Ottawa and Osler hospitals.

Taken together, all of part III as written can only be viewed as an attempt to bestow upon the minister and the government virtually unlimited authority to unilaterally order and direct fundamental changes to the health care system and to do so in a top-down manner, without any traditional procedural safeguards or substantive limitations. This could well be used for more privatization of health care services, deepening the serious attack on public health care that this government has launched through the secret P3 deals for the Osler and Royal Ottawa hospitals.

There are troubling similarities between the accountability agreements proposed in Bill 8 and the health care performance agreements recently adopted by the BC Liberal government. Both flag the compensation of chief executive officers of health authorities. In BC, the per-

formance agreements require health care authorities to establish performance-based compensation for CEOs and a reduction in spending on support and administrative services. The Daily News, Kamloops, notes: "Chief executive officers of BC's six health authorities will pocket fat bonuses if they make cuts that surpass criteria set out by the provincial government"—in other words, an incentive built into these agreements to slash and burn the front-line services, and the CEOs end up getting fat bonuses as a result of laying off workers.

Hospitals in Ontario have been forced to run deficits to defend health care in communities. We know this is a concern to the provincial government, but it is very important for hospital boards and hospital managers to be, first and foremost, focused on defending the health care of their local communities. Separating top hospital CEOs from their local communities is not a long-term solution to hospital deficits.

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As we noted above, more accountability to government may mean less accountability to local communities. We believe it is very important for hospital boards and hospital managers to be primarily concerned with the health care of their communities.

The takeover of community care access centres by the provincial government is instructive in this regard. In 1996, the provincial government established 43 community care access centres to govern delivery of home care in Ontario. The CCACs were directed to contract out services through a competitive bidding process. In this process, private for-profit corporations were invited to compete for contracts against the non-profit service providers. For-profit companies won contracts across Ontario.

This did not resolve the problems in the sector—far from it. In 2001, the government responded to increasing home care costs and campaigns by CCACs for better funding by sacking the CCAC boards and replacing them with their own people. They took the community out of the boards. The fight back by CCAC boards immediately died away and the result was significant cutbacks in funding and, most importantly, in home health care services. The effect of this was a reduction of 115,000 patients served between April 2001 and April 2003, and six million hours of services were cut—a 30% drop.

Out of necessity, hospitals have incurred significant deficits. But replacing accountability to the community by accountability to the government is not the way to resolve this issue. Indeed, if BC is an example, it may well threaten community health care.

If there is a problem with health care funding, it has not been driven by service and administrative employees. These bargaining groups are some of the lowest-paid employees working in the health care system, yet we are presently the main target of hospital privatization and restructuring.

Stats Canada figures indicate that staffing by hourly rated employees has not increased significantly since 1995, despite a large growth in the number of nursing

home beds. The total increase, less than half of 1%, is significantly less than the growth in the population of the province, and does not account for the aging of the province. Notably, hourly paid hospital staff have decreased by 12,000 employees. As well, the average weekly hours for hourly paid hospital employees, excluding overtime, has declined by 3.4% since 1995, from 32 hours per week down to 31 hours per week.

In this context, wages have largely followed inflation, so it is not surprising that a recent study by the Canadian Institute for Health Information has revealed that Canadian hospital expenditures on support services have declined rapidly as a percentage of hospital expenditures. Indeed, in the most recent period for which information is available, 1995 to 1999, there was an absolute decline in spending on hospital support services.

The only part of the health care system that is controlled by for-profit corporations has seen by far the largest cost increases, far outstripping health care sectors where public not-for-profit delivery plays an important role. For example, in 1997-98 the Ontario drug programs were budgeted at \$800 million. By 2003-04 they were budgeted at \$2.4 billion—a whopping 200% increase in just six years, four times the rate of increase in funding for all health care sectors.

In conclusion, we'd like to say we're not sure why the government chose to introduce a bill that gives such sweeping powers to the Minister of Health and Long-Term Care. We believe this committee needs to review the full amendments put forward by the government after they are available. The minister indicated that this bill should not be able to open collective agreements. This must be established through amendment, without loophole or ambiguity. If the government truly means what it says, then this should present no problem. Indeed, such amendments will rebound to the government's credit.

We also believe that this committee, and especially the members from the governing party, should reconsider the powers the bill gives the Minister of Health and Long-Term Care to reorganize and restructure health care. The hospital system has already undergone extensive reorganization over the last 10 years. Allowing the minister to unilaterally impose more is a recipe for strife, chaos and more privatization of health care services. As well, we must ensure that accountability to communities is not undermined by the type of accountability to government that this bill proposes. A wedge should not be driven between hospital CEOs and their communities.

Health care workers have lived through previous rounds of hospital restructuring, cutbacks and SARS. They have been a key force moderating the increased cost of health care. They should not be pushed to the brink through giving almost unlimited powers to the Minister of Health and Long-Term Care to launch yet another round of health care restructuring, with the threat of privatization hanging in the air.

With this, we hope the committee and its members can work with us to ensure that Bill 8 is amended so that

collective agreements are not threatened, Bill 8 is adequately amended to maintain real community accountability and limit the minister's power to force accountability agreements and issue compliance directives, and finally, Bill 8 truly eliminates threats to public medicare by shutting down for-profit MRIs, CTs and P3 hospitals and replacing them with public facilities.

I'd like to thank the committee for listening.

The Chair: Thank you, Mr Ryan. You've left us with somewhere between three and four minutes for questions, starting with Mrs Witmer. They'll have to be brief ones.

Mrs Witmer: Thank you very much, Mr Ryan. I think you and your group have done an absolutely fantastic job of summarizing the concerns that you have with the legislation and the concerns that you have for individual union members whose jobs obviously could be in jeopardy.

When the government introduced this bill, the headline was, "McGuinty Government Moves to Outlaw Two-Tiered Health Care in Ontario; Would Stop Creeping Privatization." I guess you've said here, according to your interpretation and analysis, that this bill does nothing of the sort. I guess you see it going exactly in that way.

Mr Michael Hurley: Thank you for the question, Mrs Witmer. On the P3 hospitals alone, we're anticipating bed cuts of 30% and staff cuts of 25%. When we're told by the OHA that all future hospital redevelopment will be done through accessing private capital in P3s, it will mean across the system a reduction of that magnitude. That's going to mean dramatically reduced accessibility to these services, and that's huge. In that sense, this bill represents a smokescreen for the true drivers, which are the drugs, the doctors' fee-for-service billing systems, and this push for privatization, which is going to be a huge escalator for health care spending and is going to reduce accessibility big time.

The Chair: Mr Marchese, one brief question.

Mr Marchese: Quickly. We all probably agree that the principles set out in the preamble—some good; there's no doubt about that, right? Then you go on to say that it does nothing to stop P3s, which is true; it does nothing to close private MRIs, which is true; it does nothing to end competitive bidding in the home care sector, which drives down wages and benefits for health care workers and disrupts continuity of care; it does nothing to implement Romanow's recommendations regarding pharmacare; it does nothing to protect the universality of health care programs in Ontario, as the Liberals are clearly considering changes to the Ontario drug benefit; the health council has no specific powers; it just advises. What the heck does this bill do?

Mr Ryan: We've lived through eight years of Tory Orwellian statements where bills are introduced and they do exactly the opposite of what they were intended to do. I was expecting real change. I was expecting the Liberals to get elected and basically say, "OK, we're going to deal with these problems in the health care system." We were very pleased—let's go back a little bit.

Prior to the election, CUPE was making noises and had serious concerns about P3 hospitals. We got clear, unequivocal statements both from the Premier and others, at the time he was the leader of the opposition, that they have absolutely no intention of allowing P3s in this province. Lo and behold, they're only elected a wet day and they turn around and basically play games with mortgages versus lease-backs and in essence what we're left with is a P3 hospital.

Speaking to the minister and to David Caplan, who is dealing with infrastructure, they're making it clear that this is the model that they're going to pursue and they're going to put this before the public and CUPE can make its case to the public and they'll make their case to the public. So in other words, we're going to have a battle in this province over front-line workers earning \$19, \$20 an hour or the \$9-an-hour model that they've got in British Columbia.

I'm going to say to the Liberals, that's a battle that we're more than happy to take on. We will take this fight on. We'll take it to every hospital, to every community. We'll take it to your constituency offices. You have not heard the last of CUPE on this front. You either come out front and ban P3 hospitals, be clear and unequivocal about it, or we're going to get into one major battle in this province about the future of health care. We will not sit back and allow this government to privatize the health—

The Chair: Mr Ryan, thank you. Your time has expired, unfortunately.

Mr Duguid: I've still got a minute left.

Ms Wynne: Sorry, Mr Chair, I just wanted to clarify. When there's a minute left for each question, my understanding is that that's the time for the party, but the answer doesn't necessarily have to fall within that minute. Is that not the case?

The Chair: That's not the case. The entire delegation—

Ms Wynne: Why not?

The Chair: Because if that was the case, we'd still be here from last night, probably.

Ms Wynne: That's not my experience. OK. All right. Fine. Thanks.

The Chair: With 20 minutes for each delegation, it is tough. The members could assist by asking shorter questions and allowing more time for the answers.

Ms Wynne: It's just a little hard to control the length of time of the answer. You don't want to cut people off, but yes.

The Chair: I think we just saw an example of that. I'm trying my best.

Ms Wynne: You're doing a very good job.

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CASSELS BROCK AND BLACKWELL LLP

The Chair: Our next delegation is Michael Watts, partner with Cassels Brock and Blackwell. You have 20 minutes, sir. You can use that any way you like. At the

end of that time—that's what we were discussing—any time that is left over will be used for questions—from all three parties, we hope. The floor is yours.

Mr Michael Watts: Mr Chair, ladies and gentlemen of the standing committee, my name is Michael Watts. I am a partner responsible for the health law practice at Cassels Brock and Blackwell LLP. I was called to the bar in 1991 and have been practising exclusively in health care for the past eight years.

In the past year, I've provided legal advice to over 100 health care organizations in the province, including teaching, community, rural and northern hospitals, long-term-care facilities, independent health care facilities, private sector clients and individual health care practitioners. Relevant to today's discussion, I have also previously provided legal advice to five of the province's last six provincially appointed supervisors and the Ontario Association of Community Care Access Centres and their 43 members in their final deliberations relating to their legal rights under Bill 130.

I have read a number of presentations made to the committee, including yesterday's made by the OHA. I do not intend to repeat what has already been highlighted in the OHA's report that the bill, even with the minister's proposed amendments, seriously undermines the province's hospital volunteer board structure. Instead, I want to focus on what I perceive to be two of the greatest dangers of part III of the bill as currently drafted, which are (1) the shift of control from voluntary boards to the minister, and (2) the resulting increased likelihood of arbitrary political interference in the governance and management of hospital operations. I'll address each of my concerns separately.

The shift of control from the boards to the minister will occur if the CEOs are subject to sections 21, 22, 26 and 27 of the bill; if the bill does not specifically require the minister to act in good faith and the public interest in negotiating the accountability agreements and issuing the compliance directives; and if the performance monitoring process for the determination of the issuance of the consequences or incentives is not transparent and independent.

With the shift of control, our health care system will become less accountable, not more accountable, because our communities will eventually lose the advocacy voice that volunteer boards and their CEOs to this day have been able to provide for them. While the advocacy role of boards does on occasion create tension between the government of the day and the hospital board, it should, in my opinion, be viewed as a healthy tension that helps make both parties more accountable to the public.

With the shift of control, CEOs will be more accountable to the minister, local MPPs, the deputy minister, the assistant deputy ministers, the regional director and others within the bureaucracy. This shift will occur immediately upon proclamation of the bill regardless of whether the minister ever uses the extraordinary powers. With the shift, the CEOs will be less accountable to the board, the community, the patients and the hospitals'

internal stakeholders. Over a matter of time, there is a great risk that the boards will be converted to advisory boards rather than governing boards. As a result, we will lose accountability in our health care system, as the boards will no longer be able to govern or advocate on behalf of their communities.

In my opening remarks, I shared with you my previous experience. I think that the experience most relevant to my concern expressed above that the silencing of the boards will result in the loss of accountability is my experience in representing the Ontario Association of Community Care Access Centres with respect to Bill 130.

Bill 130 was the bill that the Conservatives passed in December 2001, which converted CCACs into government agencies. Pursuant to the legislation, the government now appoints board members and the executive directors by order in council, and can terminate the CEO at any time. I have reviewed excerpts of comments made in the House with respect to Bill 130 by Mr Caplan, Mrs Lyn McLeod and the current Minister of Health which essentially highlighted their concerns that Bill 130 would silence the CCACs' boards and their CEOs with respect to advocating on behalf of their patients and that, accordingly, public accountability would be lost. For brevity's sake I will refer to excerpts of their comments. You have fuller text in your handout.

From Mr Caplan: "This is unbelievable. And we don't want to let the people who are the health care advocates, community care access boards and their executive directors tell the public about this, so we're going to give them a gag order. That's what Bill 130 is, pure and simple. It says the minister will decide. There's no public accountability. It's accountability to the minister. If the minister gives her directions and says, 'You shall,' or 'You shall not,' that is what happens."

From Mrs Lyn McLeod: "Talk about intimidating. Talk about a power for silencing. Is it any wonder that we are not likely to hear the outraged voices of executive directors of community care access centres across the province when they know they can be fired without notice and fired without severance and when they see the evidence before them in this bill that all they have to do to warrant that kind of hammer being brought down is dare to speak on behalf of the clients their agency serves?"

From the current Minister of Health: "For anyone who was at home and listening and subjected to that, here, in less than seven minutes, is the straight goods on a bad bill, one more bill from a command-and-control government that seeks to gag the voice of the local communities...."

"Let's be clear. The word 'respecting' may be in the title of the bill, but respect, as it relates to local communities and as it relates to the patients in this province, ends right there."

The previous speaker identified the impact that the loss of the volunteer boards' right to advocate has had on the services provided by the CCACs. I'm fearful that if

this legislation passes in its current form, the same will happen to hospitals and their CEOs.

I'll move on to my second concern, which is political interference. Basically, the context of these comments is the work I've done with five of the last six provincially appointed supervisors. The more control the government has over hospitals and their CEOs, the more the spectre of political, partisan interference is likely to arise in the day-to-day operations of a hospital. We believe that with the introduction of accountability agreements, the hospitals' stakeholders are likely to perceive that the minister and local MPPs have greater accountability and control over the operations of the hospital. As a result, the stakeholders are more likely to seek the help of their local MPP and the minister in influencing decisions relating to the governance and management of the hospital. Contrary to the minister's intention of making health care organizations more accountable to their communities, we believe the more likely outcome is that the organized stakeholders in the communities, rather than the members of the community, will be able to exert greater influence on the hospital's operations. In addition, further accountability to the community is lost because the minister will be able to issue the compliance directives without considering the public interest, which is a requirement under section 9 of the Public Hospitals Act, or without getting an order in council. The minister will be able to act unilaterally with respect to these extraordinary measures. We believe that to be able to use extraordinary measures, the minister should be required to consider the public interest and also seek Management Board approval with an order in council. What measures will be put to ensure that the minister acts in good faith and in the public interest when the minister issues compliance directives?

Further, why does the government believe they need the power to issue directives to the CEO? The hospital can be made to comply with the ministry's requirements via directives to the board, pursuant to the Public Hospitals Act, leaving the CEO free of dual accountability.

There are other concerns I've identified in the handout, which you can read at your leisure. My final comment is that like other presenters before me, I'm hoping that when the proposed amendments are made, this committee will have another opportunity to consider them and to give the communities opportunities to present again to you on those proposed amendments. Thank you.

The Chair: Thank you. I appreciate that the length of your presentation has left us with 12 minutes. That will be four minutes from each party, starting this time around with the New Democrats.

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Mr Marchese: Mr Watts, you pointed out some powers that the government has under the Public Hospitals Act already, and some of those powers include: the ordering of an audit; they can send in a supervisor; they can take over a board; and many other powers probably that I'm not aware of. That's true, isn't it?

Mr Watts: Yes, it is true.

Mr Marchese: In your view, why would a government, given that they already have such a power, want to then introduce another bill that gives them the same power or more power?

Mr Watts: My concern about the distinction between the proposed bill and the Public Hospitals Act with respect to your question is, under the Public Hospitals Act there are certain protections in terms of ensuring that the decisions of the ministry are made with regard to the public interest, and also with regard to having a requirement to obtain the Management Board's approval and an order in council.

For example, we have in the past questioned a minister's decision to appoint a supervisor by bringing forward an application for judicial review based on the fact that the decision wasn't made in good faith, nor was the decision made in the public interest. Under the proposed bill, we would not have been likely to even consider bringing such an application because there is no requirement under the bill as it's presently drafted.

Mr Marchese: Again, it seems odd, at least for me as a New Democrat, because I've been around with Liberals for many years and they have opposed every centralist effort, every autocratic effort made by the previous government—Bill 26 and others; you made reference to Bill 130 as well. They opposed these kinds of things. It puzzles me as to why it is that they have such an interest now to move ahead with this Bill 8, which gives the minister incredible powers. It's a political question, I imagine. I don't know.

Mr Watts: I don't mind commenting. I believe essentially, as do most people in the industry, that there is a need for performance or accountability agreements. One of our clients recently had a stakeholders' review, and patients, employees and community members all agreed that hospitals should attempt to balance their budgets, which is a drastic shift from three, four or five years ago. The issue is, how do you hold an organization accountable? The best way of holding the organization accountable and not creating great harm in the system, a system that's already extremely complex to govern, is to hold the organization accountable. The BC auditor's report contains very good information as to what should go in an accountability agreement, and then it's critical that the board be held accountable internally or hold its employees, through the CEO, to account for performance.

Mr Marchese: But you have concerns about that.

Mr Watts: Great concerns. I'm here not paid by any client; I'm here because of my great interest in health care governance and the risk of great harm that I see pursuant to this legislation, and it primarily relates to the experiences I've had with clients being asked to go to Queen's Park and answering to local MPPs on such arbitrary issues as, "Why are you transferring six nurses from community A to community B? Why have you decided to shut down the ER at one of your four hospital sites?"

Many ministers in the past have said hospitals must be accountable and hospitals must balance their budgets, but

very few ministers and local MPPs stand up to the pressure that results in such decisions in their communities. So when the communities bring pressure upon the minister or the local MPPs, they run to the Minister of Health, they call in the staff, the CEO and the board chair, and they say, "You can't do that." So it's sucking and blowing at the same time, and I think this performance agreement, unless carefully crafted, and the ability of the minister to hold a CEO directly accountable will greatly increase the risk of arbitrary political interference in the operations of a hospital.

The Chair: Thank you, Mr Watts.

Ms Wynne: I just want to be clear, because in that last gambit I got a bit lost. What I think I'm hearing you say is that there does need to be an accountability relationship.

Mr Watts: I'm saying that most people agree there is a need for an accountability relationship. The issue is, how do you implement it? Under the current bill, I think there are some great deficiencies that should be addressed prior to implementing the accountability agreement framework.

Ms Wynne: Right. So you think that the accountability agreement should be between the government and the organization, not an individual?

Mr Watts: Correct. However, the proposed amendment of the minister does still allow the minister to invoke sections 21, 22, 26, 27, so those changes are not substantive. The ability of the minister to issue directions to the hospital CEO must be removed.

Ms Wynne: OK. Just to be clear, we don't have the final wording of the amendments. Those are not written in stone anywhere yet. They're still in process. We don't have the final wording. Sections 21, 22, 27 are all going to be amended. The ability of the minister to reach in and deal with the CEO is the absolute last resort. The relationship is between the minister and the organization, exactly what you've laid out. Could you identify for us what you think a key characteristic of such an accountability agreement would be? You've agreed that it needs to be in place, you've agreed that it needs to be between the minister and the organization, which is exactly what this legislation is laying out. What would that framework look like?

Mr Watts: I'd like to address one of your earlier comments, though. I was here when the minister made his introductory comments, and the minister clearly indicated that he still intended to keep the power to issue compliance directives and require a CEO to enter into an accountability agreement.

Ms Wynne: As a last resort.

Mr Watts: As a last resort.

Ms Wynne: And he already has the ability to put a supervisor in place under other legislation.

Mr Watts: Correct, so if I can please finish.

Ms Wynne: Yes.

Mr Watts: Essentially, the extraordinary measures that he referred to, I agree they should be extraordinary; however, I disagree with the fact that if that decision is

unilaterally within his powers it is an extraordinary event. In order to be an extraordinary event, I suggest that the same process that's identified under the Public Hospitals Act for appointing a supervisor or an investigator be followed.

Ms Wynne: What will define it as extraordinary are the things that have to happen leading up to that, and that's exactly what will be laid out in the amendment.

Mr Watts: I'm here to make one point, and that point is that if the minister has the ability to enter into accountability agreements with the CEO or to materially alter a CEO's agreement—

Ms Wynne: Which he doesn't.

Mr Watts: —which is currently in the bill, that this will cause great havoc in the hospital system.

Ms Wynne: I appreciate your point. It's taken. The accountability agreement will not be with the CEO; it will be with the board of the organization.

Mr Watts: The minister has kept the ability to use sections 21, 22, 26 and 27 with respect to the CEO. There is not a substantive difference, in my opinion, if those powers remain. The harm will be immediate.

I represent probably over 50 or 60 hospitals. I've spoken to a number of the CEOs about this section and, of the ones I've spoken to, everyone has agreed that if this legislation comes through, they will immediately be more accountable to the Minister of Health, the deputy minister, the assistant deputy ministers, the regional directors, and that their accountability to the board will have drastically changed and, in my opinion—I worked for a previous government on the divestment of mental health facilities. They have what's called community advisory boards. Community advisory boards are recognized by all as having little governance influence. You will be converting hospital boards into community advisory boards if you allow the minister to directly reach in and hold the CEO accountable to him through sections 21, 22, 26 and 27.

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Mrs Witmer: Thank you very much, Mr Watts, for a very thorough and insightful presentation. I certainly share some of the concerns you have. The one point that you've made I think is very legitimate and that is that this would allow for political interference. That would be a concern that I would have. I think stakeholders at the end of the day will tend to seek more help from their local MPP. I think regrettably this could influence what goes on in local communities.

If I take a look at the whole accountability section, is it possible to rewrite that section? We've heard from a few of the presenters that that entire section should be removed and rewritten. Is it possible to introduce amendments that would address the concerns that you've brought to our attention and that others have brought to our attention, or should the government begin again with the accountability section?

Mr Watts: From my reading of the BC auditor's report, I believe that something as significant as the accountability framework requires a lot more consulta-

tion and time and effort than this government seems to be willing to give to the issue. So do they have to start all over or, as part of this process, do they give the time required to consult with the stakeholders and improve upon it? I think it's just a question of timing. I don't say it necessarily has to be rewritten, but I think it definitely needs a lot of work.

Mrs Witmer: I appreciate that, because I think—this legislation was introduced. It certainly was a surprise to the stakeholders, as you know. The hospitals were working with the government on performance agreements, and then this was introduced. So we seem to be having the consultation after the fact. From what I'm hearing from stakeholders, there's not much that's going to be left untouched once the government starts to redo this bill and rewrite the amendments.

I guess at this point I would tend to recommend that the government withdraw this bill, take into consideration what the stakeholders have brought to their attention, and start again, because I don't think there's a connect between the preamble and the content of the bill. The preamble says one thing, the press release says one thing—creeping privatization, two-tier health—but what we're seeing is certainly something very, very different. I don't know if you have comments that you would like to make.

I guess the other issue is, do you see this as an attempt to get rid of hospital boards?

The Chair: This will be your closing comment.

Mr Watts: My closing comments. Essentially, the information I have is that this government seems to understand the political dangers of tackling boards front on. This bill, to me, represents a Trojan horse that essentially is going to effectively achieve the same goal over a period of time.

As I mentioned initially, my feedback is that I think the change, from my experience, will be immediate in terms of how CEOs will hold themselves accountable to boards versus the government, but that over time the boards will lose their influence. At that time there will be less powerful people on the boards, and if they do want at that time to get rid of the boards, it would be a much easier issue.

The other concern that I have about it is that if you look at the Provincial Auditor's comments about government reporting entities, this is something that might shift them toward government reporting entities. If that's the case, again, the boards will lose influence. So this is something that will have a drastic impact over time that eventually will render the boards to nothing more than advisory boards.

The Chair: Thank you, Mr Watts. We do appreciate your coming today.

CREDIT VALLEY HOSPITAL

The Chair: Our next delegation is from Credit Valley Hospital. Mr Norm Loberg is here today, and Wayne Fyffe. Mr Loberg is chairman of the board of governors,

and Mr Fyffe is the president and CEO. Welcome. Make yourselves comfortable.

Mr Norm Loberg: I'll just get a little bit of water here, Mr Chair.

The Chair: I'll explain the rules as you are pouring. You've got 20 minutes. You can use that any way you like. At the end of the presentation, if there is any time left over, we'll try to apportion that as equally as we can among the three parties for questions. I've got 11:55 and you've got the floor for 20 minutes.

Mr Loberg: Thank you very much, Chair, members of the committee. I guess it is still good morning. I'm Norm Loberg and I'm chair of the board of governors of the Credit Valley Hospital. I'm joined by Wayne Fyffe, our CEO. He's here to support me and to answer all the tough questions today.

I'm presenting our comments on Bill 8 on behalf of my colleagues, who, like me, are volunteers who firmly believe that the best form of public administration is by unpaid volunteers, members of a local board.

The Credit Valley Hospital agrees with the intent of Bill 8 to enact new legislation concerning health service accessibility and to provide for accountability in the health service sector.

As acknowledged by the Minister of Health and Long-Term Care, the Honourable George Smitherman, the original draft of the legislation left many boards, including ours, CEOs and physicians aghast. The document was seen as inflammatory and did not realistically impart what we believe was a sincere attempt by government to develop an accountability structure that will promote the best interests of the patients and communities we serve and provide an equitable standard of care to which our health care providers and administrative bodies would aspire. However, I must admit that I am feeling considerably more comfortable making this presentation to you today as a result of Minister Smitherman's proposed amendments to Bill 8, as communicated late last week.

We sincerely thank the committee for the opportunity to share our thoughts and to work collaboratively to develop legislation that will enhance productivity, accessibility, accountability and, above all else, improve access to quality care for the people we collectively serve.

I'd like to speak to four areas today: access to care, physician contracts, standards of care, and governance and administration.

Access to care: I'd like to tell you a story about an actual patient event in Credit Valley Hospital's emergency department, which is unfortunately more often the norm than the exception these days. An elderly woman is brought to the hospital by ambulance. She appears to have suffered a stroke. The ambulance attendants wheel her into the department expecting to transfer her to a stretcher in one of 40 treatment rooms, but every treatment room is full. Instead, they wait hours until she is eventually moved to a temporary stretcher bed, where she remains for the next three days until an in-patient bed is available on a proper nursing unit.

Her family is distraught of course, not because of the lack of patient care but because their mother remains confused and uncomfortable on a narrow, board-like stretcher. As much as this is upsetting to our patients and their families, it is extremely frustrating for our health care providers, who are doing their best to care for patients in cramped, ill-equipped rooms offering no privacy or comfort for patients or families. Why is this happening?

Credit Valley is situated in Mississauga, Canada's sixth largest city—and I have to say that or Mayor Hazel will be all over me. Mississauga is experiencing phenomenal growth. On any given day, we have between 20 and 30 patients like the patient I just told you about, who may wait from one day to three days before they are moved from the emergency department to an in-patient bed.

Bill 8, and more specifically Minister Smitherman's comments of February 16, acknowledge the bill's intent to "ensure that health care is available to all Ontarians, in every community in the province." We ask you, the committee, to entrench a process to establish an equitable and accountable mechanism to ensure that our patients have the same access to a patient bed and services as a patient elsewhere in the province.

We can't provide better access for our emergency patients unless we have enough in-patient beds and funding to staff them. Only then can we meet the performance targets. Performance contracts, if properly constructed, with mutually agreed-upon standards, could assist us in achieving the equity we seek for our community, so we see them as a positive.

Physician contracts: We are pleased that the proposed amendments to the legislation acknowledge the considerable challenges hospitals face in providing access to care for those patients who do not have a family physician. At Credit Valley we have eight hospitalists. There are 22 hospitalist programs across the province, employing well over 100 physicians who are required to champion the needs of acutely ill patients who arrive in hospital without a family physician and require immediate medical care. Without them, and the ability to pay them, patient care at Credit Valley would be seriously compromised.

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As well, it would seriously jeopardize our ability to recruit and retain the brightest and the best physicians to care for our patients. We're pleased that the proposed amendments recognize that this portion of the legislation should be changed to avoid serious repercussions for the people we serve.

Point 3: standards of care. We agree that standards need to be developed to ensure a patient receives the same standard of health care no matter where in the province he or she seeks treatment. However the outcomes must be achievable based on equitable funding and access to care. When this is unattainable due to circumstances relative to geographic and/or funding realities, the accountability agreements must be modified to

reflect the realities of the individual hospital's situation until such time as a level playing field has been created. We are pleased that the minister has suggested that the language in the bill be changed so that such matters are negotiable, and that the minister will not unilaterally impose accountability agreements.

Our fourth, and last, point: governance and administration. Accountability is not all about money. It's about all kinds of resources, including the human resources—doctors, nurses, respiratory therapists and support staff—to provide good, quality patient care. I know we can all agree on that.

We hold our CEO and chief of staff accountable to meet mutually agreed targets for quality of patient care, access to care, safety and sound financial management. We are pleased that proposed amendments to the bill reflect this reporting relationship. As the minister says in his letter of February 19 to the Chair of the committee, he intends to "Maintain independence of governance structure (eg, executive board) by requiring accountability agreements between ministry and the health resource provider. The health resource provider could be required to have a performance agreement with its CEO that is consistent with key performance requirements contained in the accountability agreement." That's subsection 21(2).

We believe this is our role according to the Canada Health Act: to commit to a universal, accessible, comprehensive, portable and publicly administered health insurance program.

In our opinion, we as members of the board of governors are mutually accountable to our communities, whom we represent and who financially support our system through their tax and donated dollars, and to our elected representatives at the legislative table. Our elected representatives are responsible to answer for the health care received through the public purse. We are ultimately responsible to our communities as unpaid, volunteer, private citizen representatives on our hospital board of governors. Together, through federal and provincial tax dollars and revenue generated through our own initiatives, we provide universal health care.

Notwithstanding our support for the minister's proposed revision of section 21, we do have concerns with section 27 of the bill. We acknowledge that in the minister's discussion of Bill 8 on February 16, he states that "only in exceptional circumstances" will "the ministry impose penalties directly on the CEO." We ask that section 27 be deleted from the bill, as it undermines the trust between boards and their CEOs, as well as boards and government, and is inconsistent with the spirit of the proposed amendments in section 21. Should this be allowed to stand, our ability to attract and retain CEOs will be jeopardized.

Section 27 is not necessary because the Public Hospitals Act already provides the minister with the power to intervene in exceptional circumstances. If the intent is to find less intrusive ways to fix smaller problems before they become bigger ones, then there are

existing opportunities to provide a more proactive approach to ensure consistent governance across the province and to support hospital CEOs through peer counsel and mentorship.

I refer to the OHA's existing trustee institute, which is an educational certification program for trustees. This program could be made mandatory to ensure that minimum standards of governance are met. The OHA also commissioned a task force on operational reviews, which recommends a mechanism for joint accountability and early intervention through peer support. We have copies of this report for your information. It's dated January 12, 2004, so it's very hot off the press. Both of these proactive initiatives deserve support and could eliminate the need for such heavy-handed intervention as section 27.

In summary, we believe that by strengthening accessibility through equitable per capita funding mechanisms and developing a standard, realistic and mutually agreed upon set of performance indicators, hospital boards will be better able to monitor progress and provide necessary direction for improvement. This of course assumes that accountability is a two-way street. The Minister of Health must be held accountable to inform hospitals of expectations, how they will be measured and their level of funding on a timely basis.

We are pleased to hear that the minister acknowledged his ministry must also be accountable, although it is unclear how this will be reflected in amendments to the bill.

We believe that through mutually agreed upon and publicly acknowledged performance agreements, our communities will be better served by the health care system and more willing to financially support our ongoing capital needs. We, through our performance agreement with the minister, will be accountable to government to ensure our CEO and health care providers uphold the mutually negotiated components of the agreement.

We believe accountability between the minister and the board should be consistent in every respect.

On behalf of the board of governors of Credit Valley Hospital, I'd like to thank the committee for hearing our submission today. I'm a volunteer on the Credit Valley Hospital board of governors, a position I've been proud to hold for the last five years. Like the people who work at Credit Valley, my colleagues on the board and I have only one mission: to provide good, quality health care to the patients and families we serve in our community within the scarce resources we have available to us. I believe the Minister of Health and Long-Term Care and the many people associated with the ministry want the same thing. An amended Bill 8 will help us meet our shared mission together.

The Chair: Thank you, Mr Loberg. We appreciate that. We've got about six minutes left, two minutes to the government side. Ms Wynne.

Ms Wynne: I believe Mr Delaney has a question.

Mr Bob Delaney (Mississauga West): Thank you very much for your deputation, and welcome to Queen's

Park. Thank you especially for the co-operative approach you've taken. We acknowledge the helpful and constructive tone of your comments.

I have two very quick questions for you and one that you may want to elaborate on. After the passage of Bill 8 in the form it's in now and as you see it evolving, do you anticipate having a good, constructive working relationship with the Ministry of Health?

Mr Loberg: Certainly. Particularly with the proposed amendments that were released late last week, we feel that with the modifications we've recommended, we could have an excellent working relationship with the ministry.

Mr Delaney: In that vein, is there anything in the bill that would cause the board, for example, to have any concerns about whether it should resign?

Mr Loberg: I think section 27 is still a major concern to us. We feel the performance standards should be agreed upon between the board and the ministry and the minister, and that the performance standards should be carried out by the board through the management of the organization. I think that's the classic kind of structure you would find in any organization. Our concern is to ensure that the board maintains its accountability and, in turn, that that accountability is shared with the management of the organization.

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The Chair: Mrs Witmer.

Mrs Witmer: Thank you very much for your presentation, Mr Loberg and Mr Fyffe.

We've heard a lot of concerns about the impact of the accountability agreements, particularly the fact that the CEO, in many respects, is now going to be accountable to the minister, and the minister has ultimate power—unprecedented power—to do whatever he or she wants in the future. Do you see the shift of control from the board to the minister resulting at the end of the day in your board, which represents your community and is accountable to your community, becoming nothing more than an advisory board with no real power, no ability to hold the CEO accountable?

Mr Loberg: Yes, we do. More importantly, I think the people who sit on our board want to make a difference. They represent the community, they live in the community, they work in the community and they're concerned about making sure we have the very best level of health service we can provide in our community. If they can't make a difference, if they walk into that boardroom and have one hand tied behind their back when they're dealing with those critical issues, they won't stay on the board. So we run the risk of not having the same high-quality people represented on the board.

Mrs Witmer: So if there are not substantive changes, that could be the end result?

Mr Loberg: I think that's entirely possible.

Mrs Witmer: The bill doesn't require that the minister act in the public interest. That's been brought to our attention by several presenters. Does that concern you?

Mr Loberg: I think it would have to concern anybody when a minister does not act in the public interest. There is a provision available now through the health act that allows that action to be taken. We feel that's appropriate and adequate, and protects against actions taken that are not in the public interest. That's how we feel the powers of the minister should be performed.

The Chair: Mr Marchese.

Mr Marchese: I have three questions to both of you, and I'm going to be as fast as I can.

In your brief, on page 4, you say, "We are pleased that the minister has suggested that the language in the bill be changed so that such matters are negotiable and that the minister will not unilaterally impose accountability agreements." That's what you think he's saying or what you think he said.

In the suggested changes, section 22 reads as follows: "Include notice and other due process provisions, including time frames for notice, to address development of accountability agreements, issuance of compliance directives and orders (eg, discussion process, meetings, exchange of documents/information, representations that the minister has to consider before issuing a compliance directive or an order.)"

That language doesn't speak to negotiations. It's not something that's negotiated. The minister will hear from, but in the end the minister decides what he will do. I don't see that as negotiation language. Do you?

Mr Loberg: That's the way we have interpreted the proposed amendment.

Mr Marchese: It worries me. I think it worries you if it's not written in such a way that it kind of speaks to negotiations—

Mr Loberg: I referred to the spirit of section 21, which I think sets up an environment where there can be mutual discussions and negotiations. That's where I'm looking for consistency through all the proposed amendments.

Mr Marchese: I just read the language to you, and it doesn't speak to what you're saying. Maybe Ms Wynne thinks it does, but it doesn't to us.

Ms Wynne: That's not the language of the amendment. It's the framework.

Mr Marchese: It's the framework. Wonderful. It'll come. Just wait for it.

In terms of section 27, your worry is that if we keep the language that is there, we might lose some good CEOs. But the problem goes beyond losing CEOs; the problem, as Mr Watts was saying, is that that relationship between the government and the CEO, whoever he or she is, good or bad or excellent, is a matter of serious concern in terms of who the CEO is responsible to. It's not a matter of just losing some good CEOs, because somebody will be there, it's a matter of serious concern about the relationship the CEO will have to the minister versus to the board. Doesn't that concern you as well? I'm sure it does.

The Chair: A very brief answer.

Mr Loberg: Yes.

The Chair: That's what I thought you were going to say. Thank you very much for coming today. It certainly was appreciated.

ONTARIO COLLEGE OF FAMILY PHYSICIANS

The Chair: If we can move on to our next delegation, the Ontario College of Family Physicians: Dr Peter Deimling, the president; Jan Kasperski, the executive director and CEO. Please make yourself comfortable. You have 20 minutes to make your presentation. Make it any way you see fit. Any time that is left over will be split amongst the three parties. If you would introduce yourself for Hansard, that would be wonderful. I've got 12:17. The floor is yours.

Ms Jan Kasperski: Good afternoon to all of you. My name is Jan Kasperski and I'm the executive director and CEO of the Ontario College of Family Physicians. With me here today is Dr Peter Deimling. Dr Deimling is president of the college, but he is a family physician who works full-time in a practice in Orillia and, until very recently, was the chief of staff of his local hospital.

It's a privilege for us to be given an opportunity to address the committee members regarding Bill 8. Before we do so, let me introduce you to the college. We are a chapter of the College of Family Physicians of Canada. The college has close to 17,000 members across Canada and 6,800 here in Ontario. We were founded 50 years ago and were given a federal charter to establish standards of practice for what was then a new and emerging discipline called family medicine. We were also asked to establish residency programs in family medicine in the 16 medical universities across Canada, including the five that were established here in Ontario.

Over the ensuing years, we have stayed very close to our quality and educational roots. Today, the OCFP is involved in the education of medical students and family medicine residents and the continuing professional development of family physicians throughout this province. Our mission statement, "Promoting the quality of family medicine in Ontario through leadership, education and advocacy," says it all.

We are honoured to represent the family physicians of Ontario, because being a family doctor is one of life's greatest callings. Family doctors are privileged to be at the bedside when a baby is born or when a loved one dies. We develop intense, personal relationships with our patients and their family members. Because of our broad scope of practice, our knowledge of clinical medicine and our understanding of the health care system, we are in the best position of any health care discipline to support people in making good decisions about their own health.

In addition, as we help patients to navigate our increasingly complex health care system, we see first hand what works and what doesn't work. We are here today because we believe that Bill 8 needs to be amended so that it preserves those aspects of the system that are

working and provides the legislative framework to address what isn't working.

Rex Murphy—you all know Rex Murphy—once stated that the health care system is the best example of our Canadian values put into action. He went on to emphasize that nowhere in the system are Canadian values more on display than in the relationship that family doctors establish with their own patients.

As the college chartered to maintain the four principles of family medicine, we are committed to the values enshrined in the Canada Health Act. We advocate for our patients to have equal access to care based on need and not on their ability to pay.

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We are committed to accountability in our practices, and it is very important that this committee and government understand the nature of the accountabilities family physicians have with their patients. The patient-physician relationship is central to the practice of family medicine. We establish a covenant with our patients, not a contract. A contract says, "I will do this and nothing more." A covenant says, "I will do everything in my power to provide you with the care that you need." It is this covenant with patients that is the hallmark of all that is good in our health care system. A contract with government, no matter how well-meaning it is, will never override our primary obligations contained in that covenant with our patients. It is that covenant that drives physicians to advocate on behalf of their patients.

It is the loss of this covenant that people fear when they do not have a family doctor or when they hear that their doctor is being replaced by a team. It is this covenant that makes it so difficult for the people on boards of hospitals, community care access centres and other health care organizations to restrict access even when their budget shows a deficit.

The delivery of health care is not a business based on contracts with the government; it is a calling based on covenants. The question the committee needs to ask is: Does this bill help or hinder health care professionals to meet their covenant with their patients? You need to know that we are increasingly frustrated and alarmed by our inability to meet our covenant with our patients.

Our public health care system was on display during SARS and it became apparent that it is so poorly funded and organized that it cannot meet even basic expectations. Will this bill help ensure that water, food, air and soil are safe?

Our primary health care system is in disarray. People simply can't find a family doctor. Family doctors provide 90% of the medical care that people receive, and yet one million people in this province do not have access to the main providers of primary care: a personal family doctor. The picture gets worse when we realize that 25% of family physicians are retiring in the next few years. Relatively few doctors are choosing family medicine and our new graduates are reluctant to set up family practices in these unsettled times. The preamble gives lip service

to primary health care, but the bill is silent on how primary health care will be strengthened.

Hospitals have been downsized during the last 10 years, yet the community sector has not been funded or properly organized to cope with the added demand for services. Our hospitals have been promised stable, predictable funding for many years. Their fiscal year ends in a month and we still don't know how much they will receive. Will the bill address those concerns?

This government was elected having promised change. It promised to restore our public services. Family physicians throughout this province who have been working their hearts out under untenable circumstances were very eager to roll up our sleeves and get to work establishing family health teams. We wanted to integrate those teams with well-functioning public health units, home care, community services, hospitals and long-term-care facilities.

Then this bill came out as one of the first acts of this government. We read Bill 8 with a very heavy heart. This bill is aimed at provider accountabilities but is relatively silent on government and public accountabilities. It is hard to read the various sections in this act without feeling that once again providers are left with all the accountabilities and none of the supports they need to meet those accountabilities. It's hard to accept that caring, committed health care professionals are viewed as criminals deserving jail terms for failing to comply with various sections of the bill. It's not what we expected of this government.

The major problem that government faces in Ontario is not queue-jumping, extra-billing or lack of provider accountability; the major problem is that people in this province are so concerned about the lack of access to care, so concerned that care will not be available for them or their loved ones when they need it, that they are willing to consider two-tiered medicine as a potential answer to their concerns. Instead of working with government to address these concerns, we find ourselves in a somewhat adversarial position that is not of our making and is very uncomfortable for us. We were somewhat reassured by the minister's presentation to this committee, but we still remain concerned about various components of this bill.

Let me now turn it over to Dr Deimling to tell you why we are so concerned.

Dr Peter Deimling: The preamble to Bill 8 raises expectations by recognizing primary health care as the cornerstone of Ontario's health care system. It acknowledges the shift from hospital-based care to the community, and the need for both pharmacare and home care. Yet none of the sections in the bill addresses these components of the continuum of care implicit in the preamble. The bill is silent on the government's accountabilities to enhance the primary and community sectors and on how the various sections of the bill apply to these two sectors.

The bill causes rather than relieves confusion for those of us in community-based practices. Will a physician who has signed an alternative funding contract with the

government, such as the contract signed by physicians who have formed a family health network, be held to the same level of accountability to government as a hospital that receives a half-billion dollars in funding each year? We have been reassured by the minister that this is not the case, but the bill sent waves of anxiety throughout our membership.

We support part I, which establishes the Ontario Health Quality Council; however, we feel that the functions of the council need to explicitly include monitoring of access to care. Enrolment with a family physician and a family health team would be one of the access indicators. For other selected services, the council would establish maximum reasonable wait times and compare them, community by community, with actual wait times. In those communities where the wait times are exceeded, the minister would be expected to work with the providers to develop a strategy to gain compliance with the established wait times.

We are not talking about punitive measures. We are talking about a true collaboration between government, the community and the providers to work together to provide adequate access to services. The bill needs to ensure that the council has the teeth it needs to support the government in its efforts to ensure reasonable access to care.

We would like to see the Ontario council well aligned with the National Health Council so that efforts are not duplicated. Family doctors are the backbone of our Canadian health care system, yet family doctors are conspicuously absent among the members appointed to the National Health Council. Ontario has an opportunity to recognize the key roles that family doctors play in our health care system by ensuring that our voices are heard at the Ontario council's table. We are asking to have family doctors appointed to the council and to be actively involved in the work of the council.

We recognize that the Ontario Medical Association and the Ontario Hospital Association have been working with the Ministry of Health and Long-Term Care to develop various amendments that will preserve the intent of parts II, III and IV of the bill while modifying it to ensure the appropriateness of the various sections. We will not repeat advice given to the MOHLTC by the OMA in regard to many of the provisions in part II of the bill, but we would like to emphasize that block booking fees were developed to prevent patient office visits and subsequent OHIP charges for services that can be easily handled by phone, e-mail or fax. There are many family physicians who provide such services as telephone prescription renewals who will likely revert to office visits for all medication renewals, thus initiating a fee billed to OHIP and, in most cases, an unnecessary inconvenience for patients. In other cases, the fees cover delisted and non-insured services.

Block bookings should be continued where they are appropriate. This system is well managed by the College of Physicians and Surgeons and their role in overseeing the block billing system should be included in this bill.

If section 9 were to pass as written, the rights of physicians to accept payment for services covered by third parties would be prohibited. We do not believe that the MOHLTC intends to be the direct employer and paymaster for all physician services provided in the province. However, as the section is currently drafted, that would be the case. We believe that the provision in subsections 15(3) and (3.1) of the Health Insurance Act should remain as written and be included in the bill as amendments to subsection 9(2). Otherwise, major adjustments to the funding of physician services will need to occur that will paralyze the system.

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While we do not support practices that allow people to pay to jump the queue, daily in our practices we see evidence of two-tiered medicine. The minister, in his presentation to you, used the example of a clinic that allowed people willing to pay for an enhanced cataract lens to jump to the front of the cataract removal line. This should not have happened.

But the major problem is not this rare case of queue-jumping. The evidence would show that the more expensive lens is the better lens, but only those who can afford the quality lens get the lens that providers would like to see all patients receive. Unequal access to quality products is the problem the minister should be addressing. The minister is only too aware of the fact that how one is injured greatly affects the level of care that can be provided. It shouldn't matter if someone is injured in a car, at work or in their own home, but it does. How does this bill address these common problems of unequal access to services? Will we create a bureaucracy to deal with whistle-blowers or will we use our precious dollars to address these quality issues?

While we agree with the intent of sections 14 and 15, we are opposed to the level of information sharing with the manager of OHIP permitted under the bill, especially in light of the apparent contradictions in this bill and in the health privacy act.

In addition, we oppose in principle mandatory reporting in any instance where public safety is not a demonstrated concern. The mandatory reporting of serious criminal activities has yet to be made a provision under the law. Having mandatory reporting included in this bill implies that anyone violating the spirit of sections 14 and 15 or anyone who is knowledgeable about such a violation has committed the ultimate crime. We do not believe that to be the case and would request that subsections 14(5) and (6) and 15(2) and (5) be deleted from the bill. Frankly, the idea that our members would be required by law to spy and snitch on one another is repugnant to us. The vast majority of providers are overwhelmingly honest in their dealings with their patients and with government. These sections seem very heavy handed.

In regard to part III, concern has been expressed that family doctors who sign alternative payment plan contracts with the ministry may be required to abide by the conditions in this part of the bill. We recognize that

the minister has stated that he will clarify this section in this regard, and we look forward to seeing this amendment.

In addition, many of our physicians serve in positions that included membership on the board of hospitals, long-term-care facilities and district health councils or as physician advisers to community care access centres. They are expressing concern about the dual reporting relationships of the chief executive officer to the board and to the minister. Ontario has a long and proud history of voluntary hospital and community boards. Previous governments have weakened the strength of various health care boards through this dual reporting mechanism. This bill does the same for hospitals. We would request that the bill be redrafted to ensure consistency and to restore appropriate board accountabilities for the management of their operations to our health care boards by supporting the direct reporting relationship of CEOs to all boards.

In summary, the overarching reasons for preparing this bill were to confirm Ontario's commitment to the Canada Health Act and to enhance that commitment by ensuring that accountability for the governance and management of the Ontario health care system is enshrined in law. As major providers of health care in this province, the family doctors of Ontario are committed to adhering to the principles of the Canada Health Act and look forward to enhanced accountability in the system amongst government, the public and providers.

The preamble identifies the need for collaboration between consumers, health service providers and governments, and a common vision of shared responsibility. Provider accountabilities are addressed in this bill. The supports consumers need to use the system wisely and government accountabilities are absent. Without accountable and responsible behaviours in these three realms, the intent and spirit of the bill will not be realized. Without government and public accountabilities, Bill 8 will serve to further dishearten the caring health care professionals in our system. If this bill passes as it is currently crafted, it will reinforce the message that health care professionals are once again left holding the bag for an increasingly dysfunctional system. To legislate increased levels of provider accountability with no guarantees that the resources we need to carry out our responsibilities will be available, gravely concerns us. There is much rework needed to make this bill worthy of this government, and even more work is needed to restore confidence amongst the public and providers that our system is in good hands. Thank you.

The Vice-Chair (Mr Jim Brownell): Thank you for your presentation. You have used your 20 minutes. I would like to thank you for the presentation this morning. We have the information, and it's much appreciated.

CATHOLIC HEALTH ASSOCIATION OF ONTARIO

The Vice-Chair: Next we have the Catholic Health Association of Ontario. If you would like to come up to

the table and make yourselves comfortable, you will have 20 minutes to make your presentation. Should there be time remaining after your presentation, we will divide the time between the three parties. I would like you to give your names for Hansard, please.

Mr Ron Marr: Good afternoon. It's probably getting close to lunchtime for the committee so I'll try to stay on schedule here. My name is Ron Marr and I am the president of the Catholic Health Association of Ontario. Joining me today, to my left, is the chair of the CHAO, Mr Jeff Lozon. Jeff is also the president and CEO of St Michael's Hospital. To my right is Mr Tom Reilly. Tom is the general secretary of the Ontario Conference of Catholic Bishops.

Before I comment specifically on Bill 8, and by way of background to some of our concerns, let me take a few minutes to tell you a little bit about the Catholic Health Association of Ontario and our membership and Catholic health care in this province. The CHAO is a voluntary association of all Catholic hospitals, long-term-care facilities and community health services in the province of Ontario. There are 29 such institutions and services in this province ranging in size from large teaching hospitals, long-term-care centres and psychiatric hospitals in our major health science centres to smaller facilities in mid-sized and rural communities. Many of these institutions are multi-site facilities.

Also included in our membership are the seven religious communities of sisters and lay groups that sponsor these facilities, as well as the Ontario Conference of Catholic Bishops, which is composed of all the Catholic bishops in the province.

Catholic health services strive to provide the best-quality care with respect and compassion to all in need regardless of religion, socio-economic status or culture. We collaborate in open partnership with other members of Ontario's health care system and we are dedicated to voluntary community governance to ensure accountability to the government and to the residents of the local communities in which we serve. Voluntary governance is also a key to the maintenance of the Catholic health ministry in this province.

Our member health organizations have more than 150 years of history of providing exemplary care in all parts of this province. We have an outstanding record of good stewardship and have taken leadership roles in many areas of need. We were among the first to work with Ontario's more vulnerable groups, such as those with HIV and AIDS and the elderly. We have set high standards in providing palliative, pastoral and spiritual care as well as in clinical and organizational ethics. Most recently, we have accepted responsibility for several inner-city health and mental health services. We collaborate with others for the community's welfare and for the health of all.

Catholic facilities reflect a proven, community-based voluntary approach to governance. Our boards of directors are representative of the cultural, linguistic, socio-economic and religious composition of the communities in which our organizations are located.

The Catholic Health Association of Ontario wholeheartedly supports the overall theme and intention of Bill 8: the preservation of a universal public health care system in Ontario. The association and its member hospitals, long-term-care facilities and community services are committed to the five principles of the Canada Health Act. Also, and most important, the fundamental values of accountability and improvements to the system are important elements of the philosophy of Catholic health care.

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With this background, let me speak specifically about Bill 8. Our written brief will provide you with the background and details of our various, and very serious, concerns about this bill. Thus, I will not go into them in detail at this time; rather, I will focus on our recommendations for amendments to the bill. We believe very strongly that major amendments to the bill are required and that these amendments will improve the bill and better aid in achieving particularly the goal of accountability.

Let me start with part III, accountability, as this is the section that causes our association and our membership the most concern.

The Catholic Health Association supports the underlying principles of sections 19 and 20 of part III of Bill 8, which appear to set the foundations and definitions for accountability within Ontario's health care system. However, much of the language of Bill 8 is unclear and confusing or left to be defined by regulation, which removes it from public scrutiny prior to becoming law. We believe that many of these items, especially those with regard to governance, are too important to be described by regulation. We feel they should be clearly discussed in the public arena, and preferably deleted from the bill or amended to better reflect the respectful partnerships existing today between the government and all health care sectors.

Even though we believe that Ontario hospitals in particular are leaders in accountability—for example, the hospital report cards—we could support the creation of agreements between the government as funder and policy-maker and the health care organization as provider. However, it is fundamental that such agreements, if implemented, must be collaborative in nature between the providers and the government and must be characterized by trust, mutual respect and collaboration. With this foundation, such agreements could include mutually agreed-upon components such as performance goals and objectives regarding roles and responsibilities and service quality, as contained in clause 19(a), and a plan and timetable for meeting those goals and objectives, as outlined in clause 19(b).

Given this support for the principle of agreements between the government and providers, we have grave difficulty with the coercive nature of part III of Bill 8 as currently drafted. This is the section that outlines the methods for achieving this most important goal of accountability. Rather than facilitating accountability, we

believe that Bill 8, as drafted, gives the Minister of Health and Long-Term Care direct and strict controls over health care providers and powers that will substantially interfere with the governance of health organizations. These provisions make the existence of all voluntary hospital boards irrelevant and will effectively eliminate Catholic health care in this province.

Part III of Bill 8 also represents a significant and fundamental shift in direction for the health care system in Ontario, from a system of non-profit charitable organizations with accountable voluntary boards that are elected from the local community to a system of government agencies. This is a strange course, in our opinion, for the government to take, given the history of the past 30 years or more, where the Ontario government has divested itself of direct control and operation of hospitals and other health services while retaining a leadership role in funding and policy. A recent example of this divestment of operations and governance is that of the provincial psychiatric hospitals to community boards. Many of these facilities are now under the sponsorship and governance of Catholic groups.

We acknowledge that Minister Smitherman, in his presentation to this committee last week, signalled that important changes will be made to the act and that he is looking forward to hearing the ideas and recommendations of the public and of this committee. I would like, then, at this time to submit to you our recommendations on how the accountability section of Bill 8 can be amended to achieve these intended goals.

With respect to accountability:

(1) We recommend that the provisions that grant the minister the right to require hospitals and hospital executives to enter into accountability agreements, to issue compliance directives to hospitals and hospital executives, and to unilaterally alter hospital executives' terms of employment be deleted from Bill 8.

(2) Rather, we recommend that accountability mechanisms be developed that establish the expectations that the minister, the hospitals and other providers have of each other; that hold voluntary community boards accountable to the government and to the public; that hold executives accountable to the voluntary community boards to carry out the operations of the hospitals; that require all agreements to be negotiated, mediated or arbitrated if there is a dispute; and that a statement be included in Bill 8 that the minister must act with just cause and in the public interest in all his requirements of health care providers.

I want to stress that, in our opinion, the accountability relationships must be between the minister and the board and between the board and the CEO of the hospital or other health sector. This latter relationship is already sufficiently addressed in the Public Hospitals Act.

(3) We recommend that the minister put in place incentives for good management and achievement of goals, rather than punishments which would remove already scarce resources from the system.

(4) We recommend that the government make clear to the public any intentions regarding potential changes to

the role of voluntary community boards. As well, if the government intends to proceed in this direction, the government should hold extensive hearings on this aspect of the bill across the province in order to hear from the public as well as the health care sector.

(5) We recommend that the language regarding personal liability in part III of Bill 8 be amended to reflect that of section 10 of the Public Hospitals Act, where a person is protected from consequences for acts or omissions committed while carrying out his or her employment duties in good faith.

(6) We recommend that personal information not be disclosed as proposed in Bill 8 and its protection be maintained as in current legislation and consistent with Bill 31.

(7) Finally, given the speech by the minister to this committee, we recommend that the minister table his proposed amendments to this act with this committee during the public hearings.

There are two other parts of Bill 8 that concern us, and I'll just quickly refer to them.

In reference to the Ontario Health Quality Council, we recommend that the hospital and long-term-care sectors, along with their boards, be represented on this council.

We recommend that the council be able to make recommendations to the minister and providers on its findings in order to make improvements to the health care system.

Finally, in reference to the Ontario health council, we recommend that the language in part I of Bill 8 be clarified with respect to specific terms such as health resource provider, and that fewer areas overall are left to be defined by regulation.

In terms of accessibility, we only have one very short recommendation. As a prelude to that, CHAO commends the government on its commitment to prevent two-tier medicine, extra-billing and user fees. However, part II of Bill 8 appears to jeopardize arrangements between hospitals and some of the physicians that hospitals currently pay directly, such as pathologists, hospitalists and on-call physicians. Thus, we recommend that these parts of Bill 8 be deleted from the act.

Mr Chair, we thank you for the opportunity to appear before you this morning. We ask the members of the committee on justice and social policy to give serious consideration to our recommendations and comments, and we'd be pleased to answer any questions that you might have.

The Vice-Chair: Thank you very much for your presentation. We have about six minutes left. We will start with the official opposition.

Mrs Witmer: Thank you very much for your presentation. I know that you've demonstrated your strong commitment to Catholic health care in providing outstanding quality and compassionate care to the people in this province. But I guess there is an indication here that this bill at face value, this supposed commitment to medicare, might also, at the same time, be an attempt to remove voluntary boards from the role that they enjoy

today. You've pointed out that if that were to happen, if indeed the CEOs became responsible to the minister and the minister could unilaterally make whatever decisions he felt were necessary, this would be the death blow to the Catholic health care system, if we had no more boards. Is this what you're saying?

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Mr Jeff Lozon: That's the position of the association, that the bill as currently constituted really does fundamentally alter the essential nature of Catholic health care in the province of Ontario, or has the potential to do so.

Mrs Witmer: So then what amendments would be required to ensure the continuation of Catholic health care in this province in the way it's presently structured and allow you to continue to deliver those services?

Mr Marr: The fundamental principle we're trying to articulate is the importance of maintaining the voluntary nature of hospital governance. In that regard, that applies to all hospitals in the province, that if you remove the boards, which in effect this bill has the potential of doing, you've virtually done away with voluntary governance. The essence of Catholic health care is based on maintaining the mission within the public health system. The people responsible for ensuring that the mission of Catholic health care is maintained are the local board elected by the members of the corporation, the sponsor of each Catholic hospital, and then the CEO is held accountable to the local board. If that chain of mission is broken, if effectively the board is powerless in areas of mission and values and the CEO is reporting directly to the minister, there is no Catholic health care, there is no guarantee that the mission of the hospital or facility will be maintained.

Mr Marchese: So many questions. It is remarkable that we have heard from so many deputants, most of whom have a great deal of criticism about the bill and so very little positive to say about it. The previous delegation spoke well about many things, and I wanted your comments. "The bill is aimed at provider accountabilities but is relatively silent on government and public accountabilities. It's hard to read the various sections in this act without feeling that once again providers are left with all the accountabilities and none of the supports needed to meet those accountabilities." I think there's a great deal of truth in that. What do you say?

Mr Lozon: I've been in the health care system for more than 25 years. When I read Bill 8, I was dismayed because I thought I had actually been contributing, but Bill 8 was a statement that I was unaccountable, that we were basically not to be trusted and that we had to be in a command-and-control environment, when in point of fact most people—I think the previous deputation, and I would include myself in this—think we're actually trying to contribute to the health care system.

Mr Marchese: They add, "It's hard to accept that caring, committed health care professionals are viewed as criminals deserving jail terms for failing to comply with various sections of the bill." Certainly it's hard not to get that impression, isn't it?

Mr Lozon: There was a very confrontational tone to the bill. I think the system has been put into a defensive perspective, in the sense that it came rather unannounced and without any prediscussion.

Mr Marchese: And the Public Hospitals Act is quite clear in terms of the powers the minister has to deal with certain problems. We heard from a previous députant, a lawyer, Mr Watts, that in the language of that bill there is a public interest component, including an oversight component, ie, an order in council, which means there's greater oversight. This particular bill doesn't have any of those oversights or public interest language. It simply gives the minister the power to come and correct you whenever there's a problem. That's certainly a big cause for concern.

Mr Lozon: Yes.

Ms Wynne: There's a bit of imagination going on and some flights of fancy, so I just need to be clear about what we are saying. Currently the government has the ability to remove boards, take over boards, put in supervisors, so I guess I'm a little unclear as to why the member opposite would be characterizing this bill as being a new authority. What we're trying to do here is introduce some accountability measures into a system that needs them. The minister has admitted that we probably didn't get the tone of the bill right at the beginning, and there are a number of amendments that I hope you'll take a look at before you leave. Those tone issues and the business about incarceration and fines and those kinds of things are going to be changed.

I'd like to hear your feedback on the public interest piece we're proposing. What we're proposing is that the public interest, which doesn't appear in the bill right now, go into the preamble as an overarching principle of the bill. I wonder if that sounds like a good idea to you.

Mr Marr: It's a fine idea. I think the tone is not the issue we're concerned about.

Ms Wynne: You raised the tone.

Mr Marr: The tone is one thing. I think specifically, if the government wants to take over and run hospitals—

Ms Wynne: Which we don't.

Mr Marr: —then do it.

Ms Wynne: We could now, but that's not what we want to do. The point is that we want to establish accountability between the boards and the minister. That's what this bill is about. It's between the boards and the ministry, in fact not getting rid of the boards but validating their role.

Mr Lozon: Perhaps I could make a comment. The act, as it's drafted, does not specifically reference any ministerial or government accountability.

Ms Wynne: That's exactly where the amendments come in.

Mr Lozon: It only references accountability agreements that are actually required to be entered into by individuals. I think you can understand why the system—not just the Catholic Health Association of Ontario—is responding in the way it is. The bill, as it was circulated, and the minister's comments, although providing some

general direction for amendment, fall short of providing specifics that the system can actually identify and understand.

Ms Wynne: Right.

Mr Lozon: You can understand why the concerns are being expressed.

Ms Wynne: Yes, absolutely.

The Vice-Chair: I'd like to thank the Catholic Health Association of Ontario for coming today to make a presentation.

STASHA NOVAK

The Vice-Chair: Next we have Ms Stasha Novak. Would you like to come up to the chair and make yourself comfortable? You have 20 minutes for your presentation. With any time remaining, we'll have a chance for the three parties to ask questions.

Mr Marchese: Mr Chair, is this the last presenter?

The Vice-Chair: The last before our recess.

Ms Stasha Novak: Good afternoon, Mr Chair and members of the committee. Thank you for allowing me to speak to you. I'm just an ordinary citizen, so I'm not going to speak on small details in Bill 8. I would like to speak to you about my experience in the health system, and I'm also speaking on behalf of members of survivors of medical and dental abuse, of which I've been a member for the last 10 years.

I'm in a lot of pain right now. I do not have dental coverage, and I have excruciating pain. Sixteen years ago a dentist assaulted me and did faulty dentistry while I was in his office. To this day, I have received no compensation for expenses etc.

I tried to write something in some order; I could not. Whatever reference I'm making to the health minister was addressed to the previous ministry, because you're all new. Unfortunately, it's like ballet: There is applause or boos for the dancer who just left the stage.

I trust that your definition of health includes oral and dental health. I trust that you support accountability and absolutely not two-tier health care for those who can pay and those who cannot.

Some of my major concerns: Apart from the fact that some people can pay extra fees and some cannot, you must be aware that some people get sick because they work or live in a toxic environment. The government that did not protect them for all possible reasons from an unhealthy environment is now the same government that would penalize them again: Pay for your own health if you can afford it; otherwise, suffer and die, particularly from an environmental illness, because it's relatively new and until you establish that you have something wrong environmentally, you are perceived as crazy. I'm quoting from a health minister, but not the present one.

1300

In a civil society, one would find a way to provide compassionate health care and alleviate pain and suffering and to honour human dignity from birth to the end of life. I'm speaking with the authority of personal experi-

ence as a child under the occupation in Europe in the aftermath of war. Health care should never be for sale or used for unethical purposes, and that includes human experimentation on a healthy individual without consent, which is a violation of the Nuremberg Code. The responsibility of doctors, dentists and all health care professionals is to the patient: Do no harm.

I find it shocking that a very ill person is mistreated in a medical or dental setting, and the same ill person is expected to sit down and write a complaint, go through three years of the complaint process through the college of physicians or college of dental surgeons and the health discipline board. Why is there such a division between health care users and providers and managers of the medical-legal-dental industry? I'm sorry if I'm so naive, but aren't we all human?

I'm sorry you have to hear this story. I'm just telling you my experience. Perhaps you'll say, why do you bother? Why come before this committee? I thank you for listening. If you want to change something, I appreciate that you're listening.

One definition of insanity is to do the same thing over and over and expect different results. Each one of you could be in my situation, but I am glad that you are not.

In February 2003, after the Toronto Star and CBC TV did a program on medical horrors, the college of physicians announced to their members that Ontario doctors had to contact their patients about any errors or wrongdoing they did to those patients. Three of my treating doctors lost their licences, and to this day, no one has contacted me. Two of the doctors lost their licences after I filed a complaint of sexual assault. At that time, they were believed, so they assaulted two other patients. I have to ask, is the person who looks the other way just a passive observer or an accomplice in crime? I have no other choice of words. I think that's what any reasonable person would say.

The CBC program Disclosure was a shocking eye-opener to a wider audience. People who chose legal action against their doctors were harassed and publicly stated they were afraid of doctors' lawyers. Some cases were in the courts unsolved for up to eight years. When CBC interviewed a medical defence lawyer, she said there was no intentional delay. But I think the government of Ontario, for a while, abdicated its responsibilities and allowed such barbaric abuse of its own citizens. To me, violence by pen and paper or by the gun is the same. Violence is violence in any shape or form.

Similarly, my case against a dentist was before the courts for about eight years. I had several lawyers. About eight years later, I had a grafting of soft tissue. That means the periodontist cut a piece of flesh from the roof of my mouth and sewed it below. It's very painful. For one month I could not eat anything but pureed food and I was taking Tylenol 3. About that time, the lawyer for dental insurance came out of nowhere. He filed a statement of defence after the case had been in an Ontario court for eight years and lied to the judge that I had a psychological problem and that I had pulled my teeth out

instead of treating them, and did not provide evidence or medical or dental reports. The judge dismissed my case, and I have to pay the dentist's lawyer's fees.

I wrote a letter to the lawyer and to the judge. The lawyer replied that I did not appeal. Perhaps he should not have lied. Where were my lawyers for eight years, and why did dental liability wait for eight years to file a statement of defence, and why didn't one of the lawyers notice? Apparently, there is a procedure when one doesn't file a statement of defence within 20 years. You can go to court and ask, "What is the problem?" Perhaps they didn't have a good defence.

My concerned doctors and dentists wrote expensive medical and legal reports to my lawyers. I suffer in pain and I have to ask that you address this irresponsible liability insurance and their lawyers. My life is not on sale. The dental work is not covered by OHIP. If I have no money, I have to suffer in pain. If I have a prescription for Tylenol 3 and no money, I suffer.

The dentist who put the crown on my teeth was not qualified to do the dental work on me, and I consider that battery and assault, and criminal assault. It should be dealt with as such, not some cover-up. The college reprimanded the dentist in question and asked him to take some more courses in dentistry after examining his dental work on my teeth. The college decided that all dental work will have to be removed and replaced by someone else, but someone else would require over \$30,000, which I didn't have.

When the dentist messes up your teeth then you develop medical problems. Some family physicians are unwilling or unable to recognize medical consequences of dental disasters. You come back to the dental profession, provided you have lots of money, and the dental profession can correct the mistake of the first dentist. Often, the dental profession cannot do much for you. Some dentists would not treat you and some would further abuse you.

In the last 16 years, I had over 500 dental appointments and I was treated by some 32 dentists at Mount Sinai clinic alone. Some of my dentists were exceptional human beings—by no means am I painting everyone with the same brush—like Dr Cutler, Dr Perlus and Dr Barzilay. I don't know if they are honoured to be mentioned here, but they are wonderful human beings. But it takes only one dentist to mess up your teeth, and because of all the dental work I suffer chronic pain, facial neuralgia, horizontal loss of bone. I had abscesses. I had numerous X-rays, panorex. I have TMJ, inability to speak and earn my living.

Prior to that, I worked in a bank for 20 years, and when I was sick the bank threw me on the street with no means for survival. I am so humiliated that I have to speak before you today. This should never happen to another human being.

I could not write to you, but I brought you an article by the dentist Dr Boudin, "Importance of Co-operation Between Physician and Dentist." It was published in the Journal of the American Medical Women's Association

in 1947. It discusses the relationship between the family doctor and a dentist. Many times dentists will discover things in the mouth ahead of a physician, and dentistry and the rest of the body are very much connected.

Please excuse me for my sloppy presentation. I am in pain as I'm speaking to you.

The Vice-Chair: We have nine minutes, so we'll start with Mr Marchese.

Mr Marchese: No questions, except to thank you for coming. If one of the members has any expertise to deal with the particular problem, hopefully they might help in the individual case.

Ms Wynne: I just want to thank you for coming as well. I'm sorry you've had to go through what you've had to go through.

I don't think I can comment on the specific issue, but on the general question of government holding medical institutions and the health care system accountable, because that's what this bill is about, do you have any specific suggestions on that issue?

Ms Novak: The leader sets the tone. The Chairman set the tone of this meeting. The symphony orchestra concert master sets the tone. So you set the tone. You can't ask every medical office to have their own agenda etc—something that is acceptable in society. We have auto insurance, but you know, in every human activity errors do happen, even human errors. But nothing have I ever read anywhere that anybody would address how to deal with that. So why are patients being penalized and excluded from the process, that all other people have? That's not fair.

Ms Wynne: So you think government has a leadership role to play in terms of setting a tone and putting those frameworks in place.

Ms Novak: Absolutely. I can protect myself from the bullies; I don't walk in a back alley. But when I go to a doctor's office, an MD or a DDS, that's what I would like to find there, not some unqualified person.

Ms Wynne: Thank you, Ms Novak.

The Vice-Chair: Thank you for your presentation.

We stand recessed until 2 o'clock.

The committee recessed from 1312 to 1401.

ONTARIO CHIROPRACTIC ASSOCIATION

The Vice-Chair: I would like to call our afternoon session to order. First on the agenda for deputations we have the Ontario Chiropractic Association, if you'd like to step up to the table, make yourselves comfortable. Just a few ground rules: We have 20 minutes for a presentation. Should you not use the full 20 minutes for the presentation part, if we have some time remaining, it'll be split between the three parties for questions.

Dr Bob Haig: Thank you, Mr Chair. My name is Dr Bob Haig. I'm the director of government and professional affairs for the Ontario Chiropractic Association. With me is Dr Dean Wright, who is the president of the Ontario Chiropractic Association. We will most certainly

take less than 20 minutes, and look forward to your questions.

Dr Dean Wright: The Ontario Chiropractic Association is pleased to provide this submission in support of Bill 8, the Commitment to the Future of Medicare Act. The OCA believes that this legislation will enable the government to take a significant step toward achieving its vision for the future of health care in this province. Bill 8 will not only protect the principles of medicare but also ensure that Ontario remains a leader in the delivery of health care. The OCA firmly agrees that the preservation of medicare is essential for the health of Ontarians now and in the future.

In his remarks to this committee, Minister Smitherman said that medicare is in need of protection. He also said that the health care system is anchored in the foundation of hospital and physician services, but to be relevant it must evolve to encompass the full continuum of care. So while medicare is in need of protection, it's also in need of reform.

The OCA represents over 80% of the 3,000 practising chiropractors in Ontario. We are regulated by the CCO under the Chiropractic Act and the Regulated Health Professions Act. Chiropractors are the third largest primary contact health profession in Ontario, following physicians and dentists. This means that citizens of Ontario can visit a chiropractor directly without the need for referral from another health care provider.

Because of their expertise and education, chiropractors are one of the six health professions with a duty and obligation to perform diagnosis and the attendant use of the title "doctor."

Chiropractors diagnose and treat patients with neuro-musculoskeletal disorders and conditions. On the whole, chiropractic practice is comprised of patients with back pain, neck pain and headaches. These are the prevalent conditions which result in a majority of the cost to society in both health care and in direct costs such as lost days at work and productivity. Some patients visit chiropractors for treatment of acute injuries related to work, sports, or slips and falls. On the other hand, some patients seek help in managing their pain from chronic conditions such as arthritis.

Dr Haig: I left Minister Smitherman's speech at the Economic Club. One of the things I can paraphrase him saying is that the future of medicare in Ontario will be largely influenced by the reform of the primary care sector. He spoke at some length of the government's plans with respect to primary care reform in the family health teams.

Primary care reform is complex, and we're encouraged by the government's commitment to move forward on it. We believe strongly in the principle of ensuring that the right service is provided to the patient by the right practitioner at the right time at the right cost. We look forward to continuing to work with the government and with others to make this happen.

In Ontario, where chiropractic is a part of the publicly funded system, the use of chiropractors by the public has risen steadily over the years. Currently, about 12% of

Ontarians visit a chiropractor annually, and over the last five years probably 40% of the population has been to a chiropractor.

This increasing utilization of services is happening for a number of reasons. First and foremost, it's because chiropractic is a safe and effective form of health care. There is in fact a considerable body of evidence that supports both the health benefits and the economic benefits of chiropractic care, particularly for those conditions that Dr Wright mentioned.

One of the results of this increased level of scientific evidence is that the Workplace Safety and Insurance Board has put in place a new program of care for acute back injuries. In fact, that program of care, which is based on the evidence, effectively mirrors the way that chiropractors treat their patients all the time: with education, with return to activities, with spinal manipulation and mobilization and with exercise. So the way that chiropractors treat these common, prevalent and costly conditions is in fact largely supported by the evidence.

The second reason for this increasing utilization is that physicians and other health care practitioners now commonly refer patients to chiropractors. This is in fact the natural evolution of community-based coordinated care that is reflected in the concept of the family health teams. This is happening on an ad hoc basis as it is. This is in fact effective health care. Using the chiropractor's expertise where it's most valuable means that the physicians can focus their expertise on those patients who cannot be managed by somebody else. With the shortage of physicians and the increasing number of Ontario residents who do not have a physician, freeing up a physician's time to focus on medical priorities is in fact a good strategy.

Medicare can only be preserved and reformed with careful planning. That planning must include better co-ordination and better use of health care professionals. That's the concept of the family health team. That planning is hampered by the fact that our system has developed with individual professions and individual institutions in regulatory and funding silos. To truly preserve and reform medicare, we need to look beyond those silos to find a way to utilize all of the available resources. We shouldn't focus so much on who to fund as on what to fund; not on which professions or which institutions to fund, but on the funding of services that are known to be and shown to be effective and evidence-based, that are shown to have a good cost-benefit ratio, and services that are not just add-ons but which take pressure off and integrate well with the rest of the system.

Having said that, I want to turn to a few of the specific provisions in Bill 8.

The Ontario Chiropractic Association supports the increased accountability measures that are laid out in the bill. There are already accountability measures within the system. The college of chiropractors has standards of practice and has a peer review program which maintains high standards for the chiropractic profession. But the

significance of the health budget to the Ontario budget means that there's no such thing as too much accountability. We understand that there is debate and discussion over the penalty clauses, and I see that Minister Smitherman has made recommendations that the accountability agreements not apply to individual practitioners. But you need to know that we were prepared to support that, and in principle, increasing accountability through accountability agreements is something that we fully support and that we think is sound.

With respect to accessibility, the act has a number of specific provisions for eliminating barriers to access, including the financial barriers of extra-billing, direct billing and block fees. In Ontario, chiropractic is partially funded, so that on each visit there is a patient co-payment. This is not considered extra-billing by this legislation because the insured service is defined as only that part of the service that is funded by OHIP. But chiropractic is an anomaly in the Ontario health care system in that it is only partially funded this way. We've pointed out that the utilization of chiropractic services is increasing and that for clinical and economic reasons this is appropriate. But because of the budgetary limitations that exist—and we all know budgetary limitations exist—OHIP coverage for chiropractic service has declined over the years on a per-patient basis. In 1970, OHIP covered 82% of a visit; it now covers about 30%. So on a typical visit to a chiropractor for the treatment of back pain or neck pain or headaches, OHIP would pay \$9.65 and the patient would pay somewhere in the range of \$20. That means that patients actually face a very significant and sometimes a completely insurmountable financial barrier to access, and this is happening at a time when the evidence points to the effectiveness of that treatment to the patient but also to the payer as well, at a time when we're trying to encourage rather than discourage co-ordinated care.

1410

When patients can't go to a chiropractor for financial reasons, it generally means that they seek an option that incurs no personal cost but which costs the province of Ontario much more. They might see a physician; they might visit an emergency room; they might take some medication that's paid for by the Ontario drug benefit plan; they might do nothing and simply have to stay off work or remain disabled for a longer period of time.

Generally speaking, that's why we say and we believe that protection isn't enough. Medicare needs to be substantially reformed, and to do that, it needs a very high-level view of it to look at how to best utilize all of the resources that we have.

Section 10 of the act provides for the government to enter into agreements with respect to dental, medical and optometry services, but not chiropractic services. Sub-section 10(2) specifically identifies the professional associations that would be a party to those agreements, namely the Ontario Medical Association, the Ontario Dental Association and the Ontario Association of Optometrists, but again, not the Ontario Chiropractic Association.

We think that Ontario has a commitment to comprehensiveness that goes beyond what the Canada Health Act says, and that's reflected in the fact that some services other than physician services are funded by OHIP. It's not just chiropractors; there are others as well. We think it would be appropriate for this legislation to reflect that commitment and be amended so that it includes those other services in section 10.

That concludes what we had to say, and there is all kinds of time. So we're happy to take questions.

The Vice-Chair: Yes. We have nine minutes, to be exact. We have the government side.

Ms Wynne: I just have a quick comment, and I think Mr Delaney would like to ask a question.

Thank you for coming and thank you for articulating your support of what we're trying to do here. You of all practitioners would understand the difficulties in shifting from a culture of treatment of illness to prevention and education and wellness. So I certainly applaud that.

I just want to clarify the issue around section 10, and I have spoken to some of your members before about this. The way section 10 is written, it lifts the language directly from the Health Care Accessibility Act. In subsection 10(3), what is possible there is for the minister to enter into agreement with pretty much anybody who meets the qualifications, and it doesn't have to be an association itemized in section 2. So my understanding is that you would be covered in that section. What we didn't want to do was to be exclusive. So that's how we're proposing it be left at this point.

Dr Haig: I do understand that that section gives the minister the ability to enter into any kinds of agreements with anyone there and that chiropractic services and the other non-physician services that are funded by OHIP could be covered by that.

What I'm suggesting is that it doesn't actually reflect as well as it could Ontario's commitment to integrating the services. We know that's where you're going, we know that's where you want to go, and this is an opportunity to further demonstrate that.

Ms Wynne: We'll take your comment. Thank you. I think Mr Delaney had a question.

Mr Delaney: It is in fact one quick question. Thank you for a very interesting brief.

One of the priorities of Bill 8 is to enable health care providers to collect and use a consistent body of data that shows how effectively health care resources are being used. In your brief, you support, to use your words, "evidence-based" service delivery and service that demonstrates "a good cost-benefit ratio." As a question to you, do you think this emphasis on measuring effectiveness is going to cause Ontarians to look at chiropractic services differently? How might this affect your members and their views?

The Vice-Chair: And as quick an answer.

Dr Haig: I can't do that quick an answer.

We're very confident that when you look at the cost-benefit ratio, when you look at the cost of providing services to treat those conditions, if you have a collabor-

ation and a coordination of care that includes chiropractic services, there are very substantial cost savings. Estimates are certainly in the hundreds of millions of dollars for Ontario.

I forgot to turn my phone off; I apologize.

The Vice-Chair: I'm going to have to stop it there. Ms Witmer?

Mrs Witmer: Thank you very much for your presentation. I'm glad, Mr Haig, that you had the \$65 or \$650 to be able to get a seat at the Economic Club luncheon that was promoted by the Deputy Minister of Health so people could hear the minister speak. It's really an interesting scenario. I think some of our health stakeholders figure they would be entitled to hear the minister speak free of charge and not be encouraged to pay.

Having said that, do you see this bill as an attempt by the government to centralize power in the hands of the ministry and the minister? Or if not, how do you see this bill?

Dr Haig: Quite frankly, I see the bill for what it's intended to be.

Mrs Witmer: Which is what?

Dr Haig: Which is a commitment to medicare. The debate that has gone on in Canada and in Ontario for quite a while is bringing people to this point of saying, "We need to recommit to this. We have to do this." Certainly, from your experience, you understand that and you understand how difficult change is as well. The measures in the bill—the accountability, the accessibility measures—are right in principle. I know there's debate and discussion about whether they go too far or do not go too far. There are some provisions that affect other professions much more than they affect our profession, but in principle it is right that Ontario makes a commitment to publicly funded, coordinated health care.

Mrs Witmer: I don't disagree. I just don't think this bill goes there. A lot of hospitals have told us it doesn't go there, as has the medical community.

The Vice-Chair: OK, moving on to Mr Kormos.

Mr Peter Kormos (Niagara Centre): I'm not going to use up a whole lot of time. Yes, that's right. I saw it: 650 bucks a table, 10 seats to a table. Is that what you were talking about?

Interjections.

Mr Kormos: I'm amazed that any member of this committee with experience would somehow suggest that's the first time this has ever happened. But what also amazes me is how people get sucked into these things. They're inevitably promoted as getting access to the minister, right? That's the subtitle. Honest, I'm telling you, I'm just amazed. I meet mayors, all kinds of officials in elected positions, some with considerable experience, who somehow think these are bona fide contacts. The ministers are at these events—and I don't want George coming here tomorrow saying, "Oh, Pete, you're wrong. I was paying full attention to every person whose hand I shook." But if you take a look, the ministers go to these events and they've got their little entourage. If you'll

notice, ministers acquire this ability to look over your shoulder as they are talking to you feigning interest, right?

Interjection.

Mr Kormos: You know what it is. They'll pass you on to their handlers at the earliest opportunity. They have no idea who you were within an hour of leaving the event. All I'm saying is that it is the money most ill spent—

The Vice-Chair: You have a minute for your question.

Mr Kormos: Thank you kindly. What have we got here? It actually was being promoted as—oh, this was the highly partisan politicization of the civil service. That's right. That's what this one was, because this was a deputy minister touting this as a chance to buy your way into the minister's graces. But I'm telling you it's a fraud, a scam. You're better off buying something late at night from one of those infomercials and hoping that it actually works than you are thinking that you're going to make an impression on a minister by going to these high-priced dinners. Gentlemen, don't get sucked in. Heck, you can hang around outside the cabinet meeting on a Wednesday morning and I'll introduce you to the minister—end of story.

Thank you very much for coming here. I'm a fan of chiropractic.

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Dr Haig: So there's no question and answer in that?

Mr Kormos: There's no question and answer.

Dr Haig: Just checking.

The Vice-Chair: Thank you very much for your deputation. We appreciate your coming.

Mr Klees: On a point of order, Mr Chair: I wonder if we could ask the parliamentary assistant to let us know if chiropractors will be listed as one of those associations, when the amendments come forward.

Ms Wynne: I think I indicated that subsection 10(3) of the legislation actually allows for chiropractors to enter into agreements with the minister. At this point, there isn't a plan to change that. I said to the deputant that we would take their comments back, but at this point the legislation actually allows for those agreements, and I think I made that clear to the deputant.

Mr Klees: It's a great opportunity to actually entrench it in legislation. That's what this is all about.

Ms Wynne: We'll take the deputant's comment back.

BRANT COMMUNITY HEALTHCARE SYSTEM

The Vice-Chair: Next we have the Brant Community Healthcare System. Welcome. Make yourselves comfortable at the table. Like the previous deputation, you have 20 minutes. Any time remaining at the end will be split between the parties to ask questions.

Mr Ray Finnie: Thank you very much. Ladies and gentlemen of the standing committee on justice and

social policy, my name is Ray Finnie. I am here today representing both the Brantford General Hospital and the Willett Hospital, which together form the Brant Community Healthcare System. With me is the president and CEO of the system, Rick Woodcock.

I have been a member of the hospital board of governors of the Brantford General Hospital for the past five years. For the past three years, I have chaired the finance and property committee, where I have found systems, processes and relationships to be of great interest compared to the business world, which I normally work in. My occupation is in the for-profit world, where things function quite differently. To put things in perspective for you, I am a chartered accountant and the president and CEO of Wescast Industries, based in Brantford, Ontario. Wescast is a global automotive parts company with revenues of almost \$500 million and 2,600 employees.

Back to the hospital boardroom: I am proud to say that volunteer boards and each member on these volunteer boards is very committed to the public we are privileged to serve and does the utmost to provide an appropriate level of programs and services to our local community in an efficient and cost-effective manner. There is a very difficult balancing act that we must undertake as we attempt to meet community demands while at the same time working with the Ministry of Health and Long-Term Care to balance budgets.

I am not here to criticize the Ministry of Health and Long-Term Care, because I recognize it also has a very difficult challenge. But it is difficult for members of the board to be accountable and responsible when operating budgets are seldom approved until some six to eight months into the fiscal year, and periodically have never been approved at all. The theory of balancing one's budget with a 2% or 3% increase over two successive years when inflation or the cost of operations is running at some 5% to 8% increase, without reducing programs or service levels, is quite unacceptable.

When approximately 75% of the operating budget is allocated to salaries and wages, and the vast majority of costs related to salaries and wages are determined by central negotiations or arbitration outside the control of the local boards, the impact on our budget is also very much out of our own control. It is my opinion that we wish to stand accountable to both the Ministry of Health and Long-Term Care and to our local communities, but together we need to find a better way.

We were told by the Minister of Health at the OHA convention this past November that volunteer boards are, and I paraphrase, a valued and vital part of the health care system in Ontario. As an Ontarian, I am very proud of our hospital industry, which is reported as having the fewest acute care beds of any province in Canada, the lowest per capita hospital expenditures in Canada, the lowest inpatient utilization in Canada, the shortest length of stay in Canada, and day surgery rates, compared to inpatient rates, higher than the average of other provinces. We clearly recognize that available resources are not without limits. As taxpayers and consumers of health

care services at the local level, we expect hospitals to be responsible and accountable, and thousands of us across Ontario are here to help achieve this goal. But Bill 8 is not the way to do it.

I wish to speak to seven aspects of the proposed legislation, which in my opinion are unacceptable as currently drafted. Please recognize that several other sections also deserve greater attention; however, we do not have the time in this presentation to address them all.

Allow me to begin by saying that we have reviewed the preamble to Bill 8 along with the draft bill itself and find a significant disconnect between these two sections. We strongly endorse the philosophy expressed in the preamble but are concerned that the recommended legislation does not fulfill the expressed intentions of the preamble.

Part I: the Ontario Health Quality Council.

I believe the proposed council is a positive extension of what is currently provided by hospital boards and district health care councils. Is it duplication? Does it provide more of what the Ministry of Health and Long-Term Care already has? Those are the important questions.

My recommendation is that an independent council reporting to the Legislature will be much more likely to hold the government accountable than a council that reports to the minister.

I further recommend that the council permit membership that may include all representative stakeholder groups. Logically, there should be a predetermined allocation of membership from non-stakeholder and stakeholder groups. Members of volunteer hospital boards and senior hospital administrators who have valuable experience and insight about the health care industry should not be prohibited from participation on this council.

Part II: health services accessibility.

We support the intention of the bill to bar two-tier medicine. There is a specific aspect of this issue that we have been concerned about for several years: the payment of global budget dollars to physicians for other than stipends for medical administrative duties, which have long been recognized as an appropriate expense. In recent years, solely due to the shortage of physicians—as an underserviced area, for example, Brant county requires some 26 additional family physicians—hospitals have been forced to pay physicians amounts that greatly exceed those that such physicians can bill OHIP.

Recognizably, the billing-funding problem may be caused by (a) a fee structure that does not adequately represent physician services provided within the hospital setting and/or (b) no system to adequately provide for all medical and diagnostic physician services to be funded from the OHIP pool of funds.

The following programs are subsidized by hospitals, as noted above, and would inevitably terminate with the impact of Bill 8 as currently drafted: hospitalists, which we currently employ at our Brantford General Hospital site; psychiatrists, as we are a schedule 1 facility; pediatrics; complex continuing care and palliative care at our

Willett site; urgent care at the Willett site; and, potentially, emergency services at the BGH site.

We understand it is not intended that Bill 8 will impact this relationship with physicians. However, it is recommended that an amendment be made which will not prohibit such payments, at least until an alternative funding mechanism is created by the Ministry of Health and Long-Term Care.

Part III: accountability.

Bill 8 seeks to tighten the reins that the minister has over hospitals and will give the minister powers that may substantially interfere with the volunteer governance and management of hospitals. Such action may bring an end to volunteer hospital boards in Ontario, a goal contrary to that expressed by the minister at the OHA convention in November 2003 and in the preamble to Bill 8.

The bill will put in place mechanisms to have the hospital CEO report to both the minister and the board, and by granting the minister the right to unilaterally alter the CEO's contract with the board, the minister is interfering with a fundamental principle of corporate governance.

Clearly, all literature supports that accountability for the corporation resides with the board. In turn, the board delegates responsibility to the CEO to run the facility and operation in accordance with its expectations. The board can only remain accountable and responsible when the CEO reports directly and solely to the board for all aspects of the hospital's operations.

Our chair, Jackie Delong, is quoted as saying: "I feel strongly that this legislation devalues the work of volunteer boards such as ours in that we are accountable for our programs and services through our one employee, the CEO, and it removes that relationship. We have clear systems in place to ensure that both his performance as a CEO and our performance as a board are regularly evaluated against high standards. If he/she is not accountable to us but to the Ministry of Health, how can we be held accountable? Furthermore, where is the ministry accountability in this legislation? This legislation appears to send the message that we are not providing quality health care services to our community and that our volunteer commitment is not valued by this government. There appears to be a disconnect between the messages from the government to work in partnership with communities and the language of Bill 8. I sincerely hope the amendments to this bill encompass our concerns."

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This bill allows the minister to invoke certain provisions of Bill 8 without the "in the public interest" test currently required by the Public Hospitals Act to deal with extreme situations, or approval of government to the extent that the CEO may be required to sign a performance agreement at the discretion of the minister in the form of an end run around the board. Further, the minister may materially change a person's—ie, the CEO's—terms of employment with the board.

Long-standing principles with respect to governance and management models would be terminated in Ontario

hospitals. For example, no board should take responsibility for a CEO who is not fully responsible to one authority. Similarly, a CEO should not agree to work for more than one master. Simply stated, the CEO could not adequately perform his or her responsibilities in such an environment.

The minister should not be given authority to deal directly with the CEO, which leads to the question, why does the minister need to deal directly with the CEO at all? The minister's goals can be accomplished by issuing directives to the boards.

I am sure you are aware of the 2003-04 British Columbia Auditor General's report, which indicates: "Traditionally, boards decide on CEO appointments, terminations and remuneration.... We found it was unclear whether the CEOs are accountable to the boards, the minister, or both. This situation creates a number of potential risks. One is that the boards can be bypassed in strategic decision-making, becoming advisory boards rather than governing boards. Another is that the CEO will receive conflicting messages. A third risk is that the CEO will view his or her job as that of management of the board on behalf of the ministry, rather than reporting to the board."

It is therefore recommended that the bill be amended to provide for the CEO to report directly to, and be held accountable by, the hospital board.

It is noted that sections 8 and 9 of the Public Hospitals Act currently provide several avenues for the minister to act with some force when he or she believes the ministry should be directly involved in hospital activities. Such forces, in the form of appointing an investigator or supervisor, currently cannot be unilaterally exercised by the minister. The minister must first convince the Lieutenant Governor in Council to take action. The authority granted through this bill would undoubtedly provide for a less onerous mechanism for the minister to become involved, a purpose that appears ironic at a time when the minister is looking for increased accountability.

On the issue of accountability, this bill clearly delineates a process that makes the CEO and the board more accountable against the very significant backdrop of the minister being required to be less accountable. Why do I say "less accountable"? There are several examples, but most evident are the following two:

(1) With respect to part III, the bill permits arbitrary government intervention in hospital operations at the minister's level, as opposed to the government, by removing the requirement for the minister to obtain an order in council with proof that it is in the public interest, or any other level of government support. The bill provides for the minister to merely issue compliance directives. Unilaterally, these compliance directives could effectively be just as intrusive as the appointment of a supervisor, because they could make the role of the board irrelevant.

(2) With respect to part I, the minister does not have to be accountable to the council for funding or levels of service, provided, however, the council is responsible to the minister as opposed to the government. There is

clearly no mechanism for the council to make recommendations to the minister with respect to the ministry's role in the provision of services or the quality of services. Needless to say, the provision of services and the quality of services are often related to adequate funding, an issue which cannot be addressed by the council.

Therefore, it appears that this bill seeks to increase CEO and board accountability while decreasing the accountability of the paymaster, ie, the Ministry of Health and Long-Term Care.

I recommend that the minister continue to abide by the provisions of the Public Hospitals Act as it relates to dealing with exceptional circumstances.

Part III: accountability and accountability agreements.

We support the concept of accountability agreements, which will improve the annual planning process and hold both parties accountable for the level and types of services to be provided to the community. Ensuring that performance goals and objectives are met on a regular basis is an appropriate aspect of our board's responsibility to the community we serve. To establish, review and monitor such goals and objectives in partnership with the ministry would be a worthwhile process that will make both parties jointly accountable.

As mentioned earlier, the hospital industry has suffered too long with budgets that are approved long after it is able to react to the impact of the approved budget within the fiscal period. The current process will inevitably continue the current situation, where reportedly 90% of the 71 community hospitals in Ontario are experiencing annual operating deficits. At our property and finance committee, we have often stated that this is no way to run a railroad, and especially not a hospital. The process, or lack thereof, is destined to lead to working capital deficits in the future.

Inasmuch as we support the concept of accountability agreements, we believe that such agreements must be negotiated in order to establish commitment and accountability from both parties; due process must provide for circumstances when agreements cannot be negotiated, when key underlying assumptions change or when disputes exist around compliance; such agreements must be signed by the hospital board and the minister; and all directives with respect to amended directives or compliance issues must be from the minister to the hospital board. Once again, the CEO remains accountable to the hospital board to ensure that agreed performance goals, objectives and outcomes are satisfactorily met.

I recommend that the concept of accountability agreements be endorsed and that the foregoing suggestions be included in the development of related policies and procedures.

Part III: accountabilities and penalties.

It is apparent that government is of the opinion that accountability only comes with the threat of penalties. It is increasingly evident through the draft of Bill 13 that the government supports significant penalties to individual members and boards. Such penalties are replicated in Bill 8. We agree with the minister's own statement that

the penalties in Bill 8 are too harsh. The penalty provisions of the bill are inconsistent with the principle embodied in the Public Hospitals Act, which endorses the concept that volunteer board members shall not be held liable or subject to actions if he, she or they are acting in good faith.

It seems to me that if volunteer boards are an integral part of the system for Ontario, the government should be supporting in actions things that would attract additional good-quality board members through education, orientation and just plain moral support, not through draconian or punitive measures such as these.

We note that the minister has issued written amendments to reduce the amount of the penalties; however, the principles delineated above are driven by the idea of penalties, not the amount of such penalties. I recommend that the principle of penalties be removed from the legislation.

Other: hospital foundation and fundraising.

The government should be concerned about the potential impact of such a bill on volunteer board members, associated foundations and the community at large. Brantford and Brant county, through a fundraising project to support the directives of the Health Services Restructuring Commission, raised nearly \$12 million in a 12-month period through the generous support of personal, corporate, association and club donations. This generous support continues, with some \$7.6 million additional dollars raised since 1999.

Currently, municipal councils in Brant believe that hospitals are and should be fully funded by the ministry for both the cost of operations and capital renovations and construction. It is apparent that in the event that local hospitals are seen as facilities of the ministry only, as opposed to locally governed facilities, the ability of foundations to generate income through fundraising efforts will be reduced. I recommend that great caution be exercised with respect to the predictable impact of this bill on local fundraising, due to the potential negative effect on our ability to attract funds at the local level.

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In summary, we as a board are alarmed and disturbed by the legislation proposed by this government.

All issues raised in this submission give us great cause for concern; however, the most significant, in order of importance are: the proposed interference in the volunteer governance and management relationship; the prohibition of payments to physicians for the provision of services which exceed the amounts recoverable from the Ontario health insurance plan—without a solution to shore up programs in underserviced communities; and the need for accountability agreements to be negotiated.

Members of the committee, Bill 8 is not the appropriate method to use to support volunteer boards who have worked through extremely difficult circumstances, often with no two-way dialogue and void of adequate funding both operating and capital, for many years. The bill has been described by many as “draconian” and “punitive,” amongst other stronger terms.

At this very difficult time in the history of Ontario hospitals, when provincial resources are insufficient to meet our growing demands in all sectors, we strongly suggest that the minister recognize the immeasurable level of commitment and support amongst staff and volunteers to fortify and sustain the system.

A significantly “tempered” bill or preferably a further period of dialogue and consultation would better enable all parties to address the challenge related to scarce resources and the need to maximize the efficiency and effectiveness of the system that we treasure so dearly.

In summary, I thank you for taking the time to seek input from a cross-section of people and organizations interested in commenting on this bill. I commend you for making such sessions available in major centres across Ontario, and I look forward to following the process and reading the legislation that evolves from this process. Thank you.

The Vice-Chair: Thank you for your presentation. That was a 20-minute presentation. Therefore, we've run out of time for questions, but we do thank you for attending here today and we wish you a good afternoon.

Mr Finnie: Thank you.

GE CANADA

The Vice-Chair: Next we have GE Canada. If you come to the table, perhaps you were here to hear my words before: 20 minutes for the presentation; any time remaining is split between the parties. Welcome.

Mr David Brennan: Thank you. My name is David Brennan. I'm the vice president and general counsel for GE Canada. On my left is Dr Millman, the occupational health physician and director of corporate medicine at GE. On my right is Dr Sax from DuPont with the same position. I'd like to thank you all for the opportunity of being able to speak to you on this matter. I think everybody now has a copy of our presentation.

We're here not to speak about the general merits of Bill 8, but rather to just speak to you about part II and the health services accessibility, and how it appears that will impact on companies' provision of occupational health services.

Before we get into the specifics, I would like to just give you a little background so you can have a context of where we're coming from. For a number of years now, there has been a growing body of evidence and research that shows a positive correlation between corporate occupational health services and improved productivity. In other words, the healthier your employees are, the more productive they are. At the risk of sounding insensitive, I guess the best way to look at it is by drawing a comparison to the equipment in a company. Companies find it prudent to invest in annual maintenance services for maintaining equipment. You've got healthy equipment; in the same sense if the employees are healthy, they're going to be productive. So, over the last few years, companies have been investing an awful lot of money—I know Mr Kormos, you may see that as a bit insensitive—

Mr Kormos: You passed the insensitivity test.

Mr Brennan: Did I live down to your expectations?

Mr Kormos: You leapt over it—superman dimensions—but I get the point.

Mr Brennan: That's good.

The Vice-Chair: Continue, you have the floor.

Mr Brennan: Companies have put an awful lot of investment into health care services for the reason that we think it's a good investment.

The concept of accessibility as contemplated by Bill 8 has not been and is not being considered as one of the factors in trying to decide whether to make these kinds of investments in health services. It's not, from our perspective, a relevant consideration. Accordingly, any impact on accessibility is purely coincidental.

Second, as background, to speak to what occupational health services amount to at GE, anyway, we've provided here a list, a number of bullets, showing the different kinds of services that are provided. I don't plan to go into those in any detail, but if you're looking at them and you have questions, we'd be happy to speak to those. The majority are not, as we understand, insurable services, but they do involve some insured services.

One that I would bring your attention to is in the middle, fitness-for-duty assessments. That's a critical area where the occupational health physicians get involved in looking at employees from the perspective of bringing them back to work if they're off on STD, LTD or WSIB claims. Their input, their technical knowledge, is absolutely vital.

As other background, as context, the physicians who are retained by companies are generally retained on an annual basis, on a fixed fee arrangement.

Are there any questions on any of those services?

The Vice-Chair: Perhaps we could have the questions at the end.

Mr Brennan: OK. These services are provided on a universal basis to all employees at the company regardless of the level, be they an administrative assistant, be they the president of the company.

The benefit to GE, as we alluded to a moment ago, is productivity. Healthy workers are more productive workers. GE believes, to date, that it has received a positive return on this investment and would like to—and plans to—continue to make that investment.

Having this service around allows us to ensure compliance with health-related legislation. We have the expertise on staff to ensure that we are complying.

Incidental benefits from these kinds of services are that we believe they complement the public health system without any additional cost to the province.

The third element of background is that GE, like many companies, has a very strong and active integrity policy. Within that integrity policy is a code of conduct and one of the key planks within that code is the requirement to comply with all applicable laws and regulations. Accordingly, if something is not permitted under the law, we cannot partake.

Looking at our specific areas of concern, we've highlighted in here the specific sections out of part II that create concerns for us.

Subsection 9(2) addresses insured services and basically says that a physician cannot provide any insured service without billing that. The only compensation they can receive is from OHIP. Subsection 16(1) addresses non-insured services. It's a bit indirect but it basically says that no person or entity can charge a block or annual fee. Then you have to look at the definition of "block or annual fee." As you can see there, it's a fee regardless of how many services are rendered to a patient that are not insured services. Our concern is, with the physicians who are compensated basically on an annual fee basis, when you look at these two sections as they're written, on the face of them, that runs completely counter to the process that's currently in place.

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As I was saying, when you take 9(2) and 16(1) together, you basically cover virtually all the services that are being covered today by the occupational health service program at GE, I believe at DuPont, and many other companies.

When you look at 15(1), there's an argument that can be made that under that section, there is a prohibitive preference being given to employees by using these services. Then on top of that, as you're aware, the penalty section is very severe.

Our conclusions from looking at this is that the rationale for GE providing these occupational services is focused solely on the achievement of corporate benefits, ie, productivity, not on their impact on accessibility to health services in Ontario. Any impact on accessibility is, we believe, minimal and purely coincidental.

The continued provision of GE's current occupational health services—if this bill is passed the way it is currently written, it will stop us from providing those services, because they'll be contrary to the law. If it is, that will have a number of implications, all of which are negative from our perspective. It will impact productivity, because we believe we are having a positive influence on the health of our employees. It will have a negative impact on employee morale, because we will be removing a benefit that is there today. It will have a negative impact on recruitment, because this is something that is of benefit, these kinds of services to employees.

The other interesting benefit that will come out of it is that GE, which is a global company—this would result in Ontario being the only jurisdiction in the world where GE would not be able to provide its current occupational health services.

In summary, our recommendation is that either the bill itself be amended or that there be regulations added that carve out this concept of occupational health services in the context of them being incidental to the primary purpose of an organization.

The Vice-Chair: Thank you very much. We have about nine minutes remaining, three minutes for each party. We'll have the official opposition.

Mr Klees: Thank you. I appreciate your presentation. If I were in your shoes, I would be recommending that this bill be scrapped, because without changing it fundamentally, you folks—I think there are two physicians sitting at the table—will end up in jail if you do what you're doing.

I think the minister has agreed perhaps to remove the jail sentence, but in the letter that we have from him, the penalties will still range from \$10,000 to \$25,000 for you folks doing your job. So that's a little bit challenging. Do you take heart in that, the fact that penalties are reduced, the minister's suggesting, perhaps down to \$25,000?

Dr John Millman: I've got a big-time concern about that, sir.

Mr Klees: And so you should have. When I look at the list of services that you provide, many of these are actually preventive care initiatives, aren't they?

Dr Millman: It's basically a preventive service that we provide.

Mr Klees: Can you, in your wildest imagination, come up with some reason why the Minister of Health would have come forward with a bill like this that sends the kind of signal that it does to your company?

Dr Millman: I have difficulty accepting why this is being put forth. I think that preventive services are an important element of health care in Ontario today. The Romanow commission made a tremendous thrust as far as preventive health care services, many of the things that we're doing at the work site. We feel that we're doing a good job at that. We feel that we are basically complementing the health services of the public health care system, at no cost to the health care system.

Mr Klees: And at a time when the minister—everyone, really—is concerned about sustainability of health care, to send a signal to a major employer that what you're doing at no cost to the government somehow becomes illegal: How rational is that?

Dr Millman: As you have presented it, it's not rational at all. It's a problem, too. We do a lot of work in prevention and I think we have a healthier workforce as a result of that. The costs to the system are minimal, if anything.

Mr Klees: So we continue to call for really the scrapping of this legislation. When you read through the preamble of the bill, the intention is very good, but once you get beyond the preamble into the context of the actual legislation, there really is no connection to reality whatsoever.

As much as the minister is saying that he'd like to amend it, our sense is that if in fact there were enough amendments that could be tabled in this room to actually do what they say, it would be so far removed from the initial scope of the bill that the House would have to find it out of order.

Mr Kormos: I suppose I'm most interested in hearing the parliamentary assistant explain to you that this isn't what the bill's intended to do, that "This was not our intention," to maybe suggest that it's a matter of "Trust us; no one would ever be prosecuted for doing these

things." "Trust us," coming from the government? Please. That reminds me of the world's three greatest lies: "Your cheque is in the mail," "Your money cheerfully refunded," and "I'm from the government; I'm here to help you."

I'll cede my time to Ms Wynne, because I take heed of your carefully prepared presentation.

Ms Wynne: You are a gentleman.

Mr Kormos: I certainly am, and I want to hear Ms Wynne defend her government.

I've just sat in from time to time on these committee hearings, because Shelley Martel's got carriage of this bill. I've not had occasion to see a single participant in these hearings who supports and applauds the bill.

These people are insisting that the whole world's wrong but them. We've had some very carefully researched presentations—fault after defect after fault after defect—and the government members are insisting that somehow all these people are wrong. The Sack Goldblatt Mitchell submission—remember that? I was here day one, and I was chastised by, I think, legislative counsel. He says, "Oh, Mr Kormos, you've got to read the bill in its entirety." Well, I knew that. I read it in its entirety, for Pete's sake, and it still stinks to high heaven.

Ms Wynne, please.

Ms Wynne: Thank you, Mr Kormos. I am actually not going to say the things that Mr Kormos said.

Mr Kormos: Not now.

Ms Wynne: I wasn't going to.

Thank you for coming down and speaking specifically to the part of the bill that you're concerned about. I understand that you would have concerns. What I want to check out with you is whether you understand that—well, you do; I know you do understand this—many of the services that you provide as a good corporate citizen are not insured services. They actually fall outside the bill. So the sections that you were concerned about won't pertain.

Mr Klees: Trust them.

Ms Wynne: No, actually it's not "Trust me."

The other thing I want to say is that I don't know if you've spoken to the officials in the ministry, but if there are questions that remain after this, I hope you'll have a chance to do that. Do you want to speak to that first?

Dr Millman: The one concern I would have is, for instance, flu shots. We developed a flu program at the work site that we feel is a very valuable adjunct to employee health. We bring it to the employees. We get a good result from that. We get a lot of people to participate. That's something that you could get at your own family doctor's office as an insured service.

Ms Wynne: Yes, so there are some—as I look through the list, most of these things are not insured. If there are some that are insured, that may be one of the things that we need to talk about with the officials, OK? But for the most part, the issues that you're raising, the services that you're providing are not insured, so they don't fall within the bill.

Mr Brennan: Can I ask you on that point on block fees, the way that's defined?

Ms Wynne: Yes, I want to speak to block fees. My understanding from your presentation is that the physicians are not charging the patients a block fee at this point. You are providing a service to your employees, right? So as block fees are defined, these are not block fees.

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Mr Brennan: My concern is that while that may be your intent, when you look at the words, we, GE, pay a block fee to a physician, and he is providing services that are not on a per-service basis.

Ms Wynne: In other words, if GE can be defined as the patient, that's your concern.

Mr Brennan: No. I don't think the legislation, the words, says that. It's broader. The way it's drafted right now, the words are broader than that. It just talks about a block fee being paid for services. These are specifically non-insured services.

Ms Wynne: My understanding of the way the bill is drafted is that a block fee would be payment by a patient to the practitioner.

Dr Sol Sax: But it doesn't say that.

Ms Wynne: OK. So that's the clarification you're looking for. All right. Thank you. We'll take that comment back.

Subsection 9(2) basically will be silent on the situation you're dealing with. Section 9 is going to be amended. I mean, there are going to be things that will fall outside this bill, and your situation is one of them.

Dr Sax: But what is the intent on things like flu clinics in the workplace that Dr Millman was just talking about?

Ms Wynne: When it comes to an insured service, that has to be clarified. I don't know, Mr Chair, if we want to get staff to actually answer the question. Would that be helpful?

The Vice-Chair: We have about a minute and a half.

Ms Wynne: Would you like to hear a comment from the staff on that issue at this point? Is there somebody who can do that?

Mr Brennan: Can they talk fast?

Ms Wynne: They can talk fast.

Interjection.

Ms Wynne: You know what? We're asking a technical question here. I'm not asking staff to make a political commitment, nor should anyone in the room.

Mr Klees: That's your job.

Ms Wynne: Exactly.

The Vice-Chair: OK. Ms Wynne has asked a question.

Ms Wynne: Can we just have a clarification on that? The flu shot issue, for example.

Mr Thomas O'Shaughnessy: Thomas O'Shaughnessy, senior policy adviser on the bill. What was the specific question?

Ms Wynne: The issue was around flu shots, so the example of an insured service.

Mr O'Shaughnessy: If a physician employed by an institution such as GE or another corporate entity provided an insured service such as a flu shot, there would be an expectation that the physician would bill the plan for that service.

Mr Klees: Is that the answer you wanted?

Dr Millman: No, that is not. It certainly isn't.

Interjections.

Ms Wynne: Excuse me. This is obviously an area where we are going to have to have further conversation. It is not something that has been talked about with the ministry officials. The fact is that we're coming out on this bill after first reading; there's a lot of time to make changes. So I encourage you to continue that conversation, and we'll take your presentation back.

Dr Millman: May I just comment briefly?

The Vice-Chair: Very briefly: 15 seconds.

Dr Millman: In the broadest sense of this whole bill, wellness covers things like flu shots. You can go to your doctor and get advice about diabetes prevention and all that. A lot of the wellness activities we do fall under that same realm of services, and we would have to bill the plan for that. We do not feel that's appropriate.

The Vice-Chair: Thank you. I would like to thank GE Canada for the presentation. We appreciate your coming to the deputations. Have a good afternoon.

Mr Klees: Chair, we should just thank the civil servant for his very specific response, which wasn't what the presenters wanted to hear, but at least it was the truth.

Ms Wynne: Which is what we trade in.

SECTION OF INDEPENDENT PHYSICIANS OF THE ONTARIO MEDICAL ASSOCIATION

The Vice-Chair: Next we have the Section of Independent Physicians of the Ontario Medical Association. If you would come to the table, there's water there. You have 20 minutes for your presentation. I went through the rules. Also, could you identify yourselves for Hansard, please.

Dr Julio Szmilowicz: I am Dr Julio Szmilowicz. I am the chairman of the Section of Independent Physicians of the Ontario Medical Association, and to my right is sitting Dr Eugene Mandryk, who is a past chair of the section.

Thank you, members of the committee, for the opportunity to present to your committee. It is a privilege to be permitted to speak with you about our concerns in regard to Bill 8.

We represent about 400 doctors who choose to belong to the section because they believe in independent practice. About 120 of us are opted out of OHIP. That is, we bill the plan for insured services at the prescribed rates no different than those for our opted-in colleagues. The difference is that the payments for these services go directly to our patients, who then pay us. In other words, we work for and are paid by our patients, who get reimbursed by the government of Ontario at the same

rates as other physicians who receive payment for services rendered deposited into their bank accounts.

I want to make sure that you all understand what this means. We get paid neither more nor earlier than our colleagues. We submit claims on behalf of our patients and bill them. They then receive a cheque and pay us. Since we wait for patients to get their cheques, we often receive payments later than our colleagues. We collect from our patients directly only after they are sent the cheques covering the services provided the month earlier.

On occasion, we wait many months to collect since patients move without letting OHIP know about their new addresses, which means cheques get sent to their last known residences. Only patients are permitted by law to notify OHIP directly and request a change of address, which can only be done reliably in person or by attending a government kiosk. Mail is sometimes unreliable and OHIP's change of address forms are sometimes—not always—not acted upon.

Rarely, patients who see us fail to remit their payment even though they are in possession of their cheques. As a result either of an erroneous address in the OHIP computer or a wilful withholding or non-payment of our bills, our accounts receivable are higher than those of our colleagues who are paid directly by OHIP. We write off considerably more unpaid balances than our opted-in colleagues, sometimes as much as a few hundred dollars every year.

So, members of the committee, you may wonder what leads us to remain opted out when it is clear that there are no advantages and clearly several disadvantages in doing so. Why is it that I, the chairman of the section representing those hard-working independent doctors, am here to draw your attention to the fact that Bill 8 would outlaw opting out? Why, if there are more disadvantages than advantages, are we complaining and wish for you to recommend that this part of the bill be revised?

The answer is simple. We are opted out and suffer from late payments, higher receivables and more frequent write-offs because we believe in working for the patients directly. We believe that by being independent, we offer our patients a doctor-patient relationship that is unencumbered by the presence of a third party who pays us without notifying patients how much we earn, when or how we bill and for what activities. We consider our patients our employers who pay us for services they know they received and are aware of the actual charges claimed on their behalf. We take pride in being independent of and yet accountable to both government and our patients. We feel employed directly by our patients.

Adding accountability to the five well-known pillars that underpin the edifice of medicare, as the bill suggests, is a responsible avenue. We support the concept of accountability and transparency since this is also our money that is being spent. Mr and Mrs Ontarian are entitled to know how much we spend, how effectively we are serving their needs and what, if anything, we must do if there are problems with waiting lists, physicians' remuneration and hospitals' efficiency.

However, we independent physicians have been practising accountability before the Romanow report was contemplated or written. We are accountable to our patients because they pay us after getting reimbursed by OHIP. They receive the cheques with which they pay us and read the stub describing each service, the date on which it took place and the amount paid for their medical care. Only our patients know how much their care costs the people of Ontario. I dare say that most patients attending an opted-in physician have no clue as to how much their doctor received on their behalf for the services they provided. We cannot bill for a service we didn't provide; our patients would quickly hold us accountable for any such actions. We cannot bill for a service different than the one we provided because the cheque stubs detail the service in question. We cannot bill for a date of service that is wrong because patients know when they attended our offices. OHIP deposits not even one cent into our accounts; it issues cheques only to patients or, as they are now called, subscribers. Opted-out physicians' claims are classified in the OHIP computers as "pay subscriber" claims. And, ladies and gentlemen, we like it that way. It is a source of self-respect to us that we are independent. We work for and are paid only by our patients. We are prepared to accept the disadvantages attending our freedoms, even with the disadvantages of higher receivables and occasional write-offs.

I am here today because the Ministry of Health has not provided us with a clear explanation as to why they need to ban opting out. One ministry official asserted that it is policy—every physician should be in the plan; no one should be allowed out. This, notwithstanding the fact that the Canada Health Act, on which this bill is based, explicitly allows physicians to be opted out should they so choose, as long as they do not ask for, bill or receive for an insured service an amount greater than that prescribed by law.

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The Canada Health Act explicitly permits us to choose to bill on behalf of patients so that they collect from their provincial insurance plan. Every province, bar none, allows doctors to opt out. In some provinces, such as Quebec, opting out means something different. Quebec physicians who opt out are allowed to charge their patients whatever they and the patients agree upon, even if this is more than the sums paid by the Régie, but their patients receive no reimbursement from the province.

Should the bill be enacted as it now reads, ladies and gentlemen, Ontario will be the only province in Canada that does not offer physicians, and patients by implication, a choice. With respect, we cannot understand the reasons for this conscription. It is true that there are very few of us who are opted out. According to the ministry, there are about 76 physicians. According to our calculations, there are probably about 120, or a few more. This represents less than one half of 1% of all physicians in the province of Ontario licensed by the College of Physicians and Surgeons of Ontario. Many are psychiatrists, like myself. Some are family doctors, and a few are

gynecologists, ophthalmologists, ENT specialists or plastic surgeons.

Is the cost of sending cheques to patients a factor? I have been told that the cheques are generated by a computer so that the only extra cost is postage. However, members of the committee, for 49 cents a month you have several hundred patients who are accounted to in an immediate and direct manner. This is the very aim of Bill C-8, as I understand it.

I am told that the medical review committee seldom reviews opted-out physicians, or at least does so less often than with opted-in doctors. Doubtless, they are aware there cannot be any cheating, as patients receive payment and then pay their physicians after reviewing the stub attached to the cheque. Isn't this the very accountability sought by the government?

It is possible the ministry believes that there are problems in accessibility to the few specialties that have the highest number of opted-out physicians. How is this the case? We cannot, and do not, bill any more for insured services than the amount permitted. Even if we did, the OHIP computer pays only the amount that is programmed and allowed. We generally wait for patients to receive the cheque before collecting. We do not demand any upfront fees that could be construed as a barrier to accessibility.

I consulted the CPSO, the college, and could not find a complaint against an opted-out physician because a physician demanded payment from a patient before they were reimbursed. Not one case, ladies and gentlemen, not one.

It is possible that the proposed ban originates from the perception that opted-out physicians are more likely to charge block fees for services OHIP does not cover. You probably know that this is not the case. Perception is in this case not the reality. Many opted-in family doctors charge block fees. I might add that this bill recognizes that physicians can, and do, properly offer services that are not insured by OHIP, and does not proscribe fees for such services.

Can you imagine banning the provision of circumcision, or cosmetic surgery, or hair removal, which was delisted by the NDP government a few years ago? They are services not considered medically necessary and/or services that the province has decided should not be covered. However, patients still seek such services, and physicians, those who are opted in as well as those who are opted out, can and do offer them. They fall within the purview of "voluntary" and are paid on a negotiated, contractual basis between physicians and patients. While such services are not paid for by OHIP, the CPSO regulates the provision of such services by all physicians, both those who are opted in and those who are opted out. Banning opting out will not reduce the number of cosmetic surgical procedures, circumcisions or any other delisted treatments, because even opted-in physicians can, and do, offer them.

In conclusion, I would like to draw your attention to the section of the proposed bill that bans opting out in the

province of Ontario. We opted-out physicians choose to do so despite a number of financial disadvantages, but value working directly with and for our patients. We practise accountability more directly than our opted-in colleagues and pose no barrier to accessibility. Our practices are transparent and every one of our patients knows how much their medical care costs. For the price of one postage stamp, our patients know exactly what, when and for what we bill the plan. Our record at the CPSO is unblemished; there are no complaints directly attributable to our practising independently. We are no more likely to charge for services that are non-insured than any other physicians, regardless of any perception to the contrary. We are happy and pleased to be working that way. From a legal point of view, the Canada Health Act mandates our freedom to choose to be opted in or out of our provincial health plans.

I respectfully remind you today of the oft-repeated but, in politics, seldom practised maxim: If it ain't broke, don't fix it. Thank you for your consideration.

The Vice-Chair: We have nine minutes remaining, so I'll split that: three minutes.

Mr Kormos: Thank you, Doctor. I'm quite frankly more interested in listening to Ms Wynne spar with you. The group of independent physicians—400 of them and only 120 are opted out. What qualifies one to belong to the group of independent physicians?

Dr Szmilowicz: Belonging to our section is voluntary, Mr Kormos. The reason for the discrepancy in the number is that many of them who feel they work independently work in hospitals, so they are not opted out. The majority of the people who are opted out work outside a hospital in an office and have traditionally been opted out since they started their practice.

Mr Kormos: Forgive me, I've never met an opted-out physician before.

Dr Szmilowicz: You've met us.

Mr Kormos: Now I know two of you. Why? Why would you do that when you put your patients through the inconvenience of having to get the cheque and remit it to you? You get some shrinkage in revenues, I suppose, because those cheques disappear or the patient moves out of town. So you've got accounts receivable that opted-in physicians probably don't have. So why would you become an opted-out physician? I don't want to be unfair, but why?

Dr Szmilowicz: As I said in our presentation, because we feel that we work more directly with our patients. They are our employers, not the government.

Mr Kormos: OK, in terms of an answer I suppose that's fair enough.

Dr Eugene Mandryk: It's a choice.

Mr Kormos: Yes. As you say, the maxim is, "If it ain't broke, don't fix it." Another maxim is, "There's an easy way to do it and a hard way to do it." But then again, who am I to talk about doing it the hard way? Ms Wynne, please, answer these gentlemen's questions.

Ms Wynne: Actually, Mr Duguid has got a question.

Mr Duguid: I'm going to take another crack at Mr Kormos's question, because I've been trying to figure

this out myself from the beginning. Is it strictly a philosophical view that the current system is not appropriate, that you want to opt out of the current system? Could you explain that?

Dr Szmilowicz: With respect, I've been opted out since I started practicing in 1978; it's not a new decision. I've always practised as an opted-out.

Mr Duguid: I recognize that.

Dr Szmilowicz: You're asking the same question and I'll give you the same answer: because I like it that way. I feel that I work for my patients more directly because my patients pay me.

Mr Duguid: I'll accept that answer. I'm just wondering, is your patient in any way benefited from this system? I don't see the benefit to the patient at all and I don't see the benefit to you, frankly, other than the fact that you like it that way.

Dr Szmilowicz: There is no benefit to me, because there are higher receivables and it's more difficult to practise that way. Is there a benefit for my patient? I would say yes, because my feeling about the way in which I work with them is different. I work for them; I don't feel that I work for OHIP.

Mr Duguid: OK. Mr Delaney, did you want to follow up?

Mr Delaney: Yes. You say 120 physicians have opted out; the Ministry of Health says 60. Let's take your number. One half of 1%, then, have opted out. Why aren't there more?

Dr Szmilowicz: Before 1986 there were 12% of all physicians who were opted out. Over the years people have felt tired, tired of having to maintain more records, tired of having to chase money, tired of whatever way. They still feel independent, but they've decided to opt in.

Mr Delaney: Among the members you keep in touch with, what percentage of their gross billing is bad debt?

Dr Szmilowicz: I wouldn't be able to tell you. I can only tell you in my case it amounts to about \$1,000 a year, perhaps a little bit over.

Ms Wynne: Do any of the opted-out physicians charge their patients up front? Does that ever happen? There's nothing to prohibit that, right?

Dr Szmilowicz: At the time of Bill 94, the Health Care Accessibility Act, there was a provision passed that we could not actually ask for the money before the patients received the cheque. I think most people abide by that. I can't tell you that nobody does that, but I can tell you I don't know anybody who does that.

Ms Wynne: That's one of our concerns. Having grown up in the household of an opted-out doctor at one point, I understand the philosophy, but that's the kind of thing we're trying to avoid, the up-front charge. That actually does affect accessibility.

Dr Szmilowicz: With respect, I don't know of anybody—I've never seen a patient who comes to me saying, "I don't want to see you because you're opted out." Nor have I seen patients of other opted-out physicians who come to see me because I work in a different way. If that were the case, I would have liked the

ministry to actually have come to us and said, "This is a problem. Can we resolve it in a different way?"

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Mrs Witmer: Thank you very much for your presentation. I respect the fact that you feel so strongly about the method of billing that you're presently using, but I'm not sure that you're going to win the battle that you're currently waging, if I listen to Ms Wynne. I think the government has made a decision and I think part of it is based on more centralized control, making sure that doctors work differently—less independently, I guess, than before. What will the impact be on your group? You've got a group of 400; you say you've got 120 who are opted out. If the government is unwilling to make an allowance for you, what will happen to the members of your group? Will they continue to practise? What's the age group of your membership?

Dr Szmilowicz: Thank you, Mrs Witmer. It's a very important question. I would say that the average age is about 60 or a little bit older, because we have been in practice for much longer than the younger graduates. There may be an unintended result from this bill and that is that maybe a few of them will retire. If they retire, instead of getting more accessibility, you are actually going to get less accessibility because there will be fewer doctors. But it's only a guess. I'm not here to scare-monger. I have no idea what will happen. But that is one of the possibilities.

Mrs Witmer: That's why I asked about the age. I guess that's what we've heard from other physicians as well, that this bill, instead of increasing accessibility to physicians, actually, because of the draconian measures that are suggested, it could have the reverse impact and could cause doctors to not stay in the province. Young doctors won't want to be so hamstrung by the government. So there's a real fear that the whole issue of accessibility could be severely impacted.

Dr Szmilowicz: Yes.

The Vice-Chair: Thank you very much for your presentation.

Mr Kormos: Chair, if I may, on a point to legislative research: This is the most interesting presentation we've just heard. In view of the fact that we can't question these people any more, I'm hoping that legislative research would perhaps obtain some answers for us: (1) the number of opted-out doctors; (2) the point at which they opted out, with a view to discovering whether opted-out doctors is an historical phenomenon such that they are going to—not disappear, but they're going to naturally—

Mrs Witmer: Attrition.

Mr Kormos: —attrition will take care of it; and (3) what problems have been encountered with opted-out doctors that this legislation purports to fix, specifically what Ms Wynne spoke to, the prospect of compelling a patient to pay before that patient receives the OHIP coverage.

I understand the Liberals' discomfort with these people because these are people of principle. Sure, I agree with them, but they are—

The Vice-Chair: We thank them for their presentation this afternoon.

ONTARIO DENTAL HYGIENISTS' ASSOCIATION

The Vice-Chair: We do have a cancellation. The Toronto and York Region Labour Council has cancelled. Bridgepoint Health I don't think has arrived yet. But the Ontario Dental Hygienists' Association is here, so we will have the deputation from the Ontario Dental Hygienists' Association.

Ms Michele Carrick: Good afternoon. My name is Michele Carrick and I'm here today representing the Ontario Dental Hygienists' Association, known as the ODHA. I am a practising dental hygienist in Owen Sound and I currently serve as vice-president of the association. I am also the incoming president.

This is my first time speaking to a committee in this format. Most dental hygienists are accustomed to speaking with a client when they're in a horizontal position, so please bear with me.

The Ontario Dental Hygienists' Association represents approximately 6,000 dental hygienists across Ontario, accounting for about 85% of the total number of dental hygienists registered to practise in the province today, making us one of the largest health professional associations in the province.

Dental hygienists do more than just remove plaque and floss teeth. We contribute in large part to our patients' overall health through the prevention of oral disease and the promotion of oral health care. Dental hygienists provide a process of care that involves assessing the oral condition, planning the treatment, implementing the plan and evaluating the results.

On behalf of our entire membership, we are pleased to be here today to provide our comments regarding Bill 8, the Commitment to the Future of Medicare Act, 2003. As a whole, the ODHA supports in principle the intent behind Bill 8. In fact there are sections of the bill that we wholeheartedly support. There are other sections, however, that we have serious concerns over and urge you to amend.

We understand that the Minister of Health and Long-Term Care has indicated that he will be submitting to you a number of amendments that may or may not address many of our concerns that I will present to you today. We are encouraged by that announcement and welcome the opportunity to review those amendments when they became available. Until then, our association still feels it's important to take the opportunity to present our opinion and recommendations with respect to the bill.

The Minister of Health and Long-Term Care summarized the intent of this bill in a news release after it was tabled in the Legislature. Bill 8 was tabled to ensure that every member of our society "has an equal right to quality health care based on need, not income." We could not agree more and we fully support that intent.

Whether it is a CT scan, laboratory work or dental hygiene services, the ODHA believes that every citizen in the province should have access to timely, quality and efficient health care. We believe in a health care system that is accountable and transparent. We also believe in the creation of a quality council to monitor and provide assessments to the people of Ontario.

The ODHA welcomes the provisions made in Bill 8 with respect to the establishment of the Ontario Health Quality Council. By working collaboratively with the National Health Council, the people of Ontario will know exactly where health care funding is being spent and what improvements need to be made to the system in terms of access. The council would also track long-term health goals set by the government and ensure that such goals are being met.

Whether directly, by having one of our members on the council itself, or indirectly, by offering any assistance our association can provide, the ODHA will do what we can to ensure that the council is a success and that it provides the most useful information necessary to improve Ontario's health care system.

On the other hand, the Ontario Dental Hygienists' Association has some serious concerns with Bill 8. They are concerns that I am sure you have already heard before, whether outlined by previous groups presenting to you or through a number of media releases from various organizations across the province regarding Bill 8.

The first concern we have is with respect to privacy and the protection of personal health information. A few weeks ago, the ODHA had the opportunity to participate in committee hearings regarding Bill 31, the Personal Health Information Protection Act, 2003. We indicated at that time that Bill 8 would set up another stream for access to and disclosure of health information, as stated in section 13 of the bill. In fact, as currently written, section 15 of Bill 8 would prevail over Bill 31 and would allow personal information to be disclosed without consent in certain situations.

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The ODHA suggests that the issue of protecting personal health information should be a very high priority for the government. For this reason, every attempt should be made to define how personal health information can be collected, used and disclosed under one piece of legislation. Simply put, to avoid confusion and to reduce costs of implementation and enforcement, the ODHA believes that there must be a single regime for the protection of personal health information in Ontario, and that regime should be the Health Information Protection Act, 2003. Accordingly, Bill 8 should be made consistent with and subject to the provisions of Bill 31.

As I mentioned earlier, the ODHA supports and strives for an accountable health care system. Through part III, Bill 8 attempts to tackle the issue of accountability; however, it goes way overboard. Herein lies the major concern of this association and elicits our strongest opposition.

Part III of Bill 8 allows the minister to direct an individual, organization or entity to enter into an accountability agreement or to make compliance directives. When such an accountability agreement is entered into or a compliance directive is issued to an individual in his or her executive capacity or to an organization, the bill allows the minister to terminate or vary said agreement unilaterally and at any time.

The bill goes on to say that an accountability agreement or directive entered into with one person applies automatically to that person's successor, even if the successor has no knowledge of this agreement or directive or was involved in its negotiation.

Further, in sections 27 and 28, the bill allows that any changes in a person's employment terms that result from an order by the minister are deemed to have been mutually agreed upon between the person and his or her employer. As well, the change does not entitle the person to any sort of payment or compensation, despite any provision to the contrary in labour laws, collective agreements or in his or her personal contract or agreement of employment.

Needless to say, part III of Bill 8 gives the minister extraordinary powers to direct an organization to fire, demote or otherwise sanction any person within the organization without any right of recourse. Bill 8 gives the minister the sole right to determine the contents of accountability agreements and to enforce compliance. In one fell swoop, part III of Bill 8 sweeps aside the Employment Standards Act and labour law in general, as well as any collective agreements and individual employment agreements.

From the provisions outlined in part III of Bill 8, the laudable desire to create an accountable and transparent health care system in the province has been nullified. The ODHA believes that if this bill is passed without further revisions, it will create an unworkable and even hostile relationship between the government and health service providers.

We appreciate the opportunity to speak to you today. We are grateful that the government is willing to listen and work together with stakeholders and service providers, seeking input and advice before submitting the bill for second reading.

That concludes our comments for today. We would be happy to take any questions that you may have.

The Vice-Chair: We do have 12 minutes remaining, so four minutes, the government side.

Ms Wynne: Thank you for coming today, and thanks for your comments. You're right; some of your comments we have heard before. I'm hoping you'll have a chance to take a copy of the framework of the amendments that are going to be introduced, because a number of the issues you've identified are going to be addressed. Section 13 is going to be amended to remove the sweeping power of the minister to directly collect, use and disclose personal information. But on that information issue, Bill 31 will prevail except in specific circumstances around collecting information for queue-

jumping. So Bill 31 is the framework and Bill 8 will only prevail in certain very specific circumstances.

On the issue of the accountability agreements, I wanted to make sure you know that in the amendments that are coming forward, it's going to be very clear that there's going to be an exclusion of trade unions and collective agreements. This bill is not designed to reach into collective agreements. That's not the point. So that's going to be articulated. The accountability agreement is going to be between the board or the provider and the minister and not the front-line employee.

Having said that, I'm just wondering—it sounds like you generally agree with the direction that we're going here, so can you talk just a little bit about the things that you think should be in an accountability agreement, appropriately and mutually designed? What are the things that you think we should be tracking? I guess that goes to the issue of the health quality council as well. What are the things you think we should be looking at?

Ms Carrick: As you know, most dental hygienists are in private practice. So most of our accountability is governed under our college, because we have our own standards of practice and codes of ethics. We do have dental hygienists who work in public health, so they would be more accountable under Bill 31. Basically, we want the government to understand our position so we can inform our members so that they understand where they have to go and whom they have to be accountable to.

Ms Wynne: We're not talking about monitoring you, but in terms of the health system—because you're part of the health system—you think accountability is a good idea. You think accountability agreements are a good idea. Do you think that there are general areas that the government should be tracking, for example, to increase accountability?

Ms Carrick: I'll get back to you on that one.

Ms Wynne: Don't worry about it. It's OK. That's why we're putting the health quality council in place. It's to set some directions and then to report on them to the public so that people have an idea how the public health system is doing and where we're going.

Mr Klees: Thank you very much for your presentation. We share your concern. You hear Ms Wynne tell you that you're not to worry about a thing, that the framework that the minister has given regarding amendments that he's prepared to make will really look after your concerns.

Life is not that good here in Ontario. I just want you to be aware you have every reason to continue to be very, very cautious and concerned, actually. The truth of the matter is that the document Ms Wynne will give you does not in any way give you comfort. It does not in any way take away the threat of section 27, where—in fact you refer to it in your presentation: the wording where it gives the minister the authority to make changes to agreements with employees. It is yet to be determined just exactly who is going to be lumped into that group.

Ms Wynne: On a point of order, Mr Chair: When something that is being said is absolutely not true, it just seems to me that—

Mr Klees: Mr Chair—

Ms Wynne: I withdraw the “not true” piece.

Mr Klees: She’s encroaching on my time.

Ms Wynne: I just want to read into the record the language of the amendment—

The Vice-Chair: This is Mr Klees’s time. Thank you.

Mr Klees: I do trust, Chair, you’ll give me credit for that time.

The Vice-Chair: Yes, I will.

Mr Klees: I will, to be truthful, read into the record here what the bill says. You refer to it as well.

“Where change in terms of employment”—I’m quoting from the bill—“the change shall be deemed to have been mutually agreed upon between the person and his or her employer.”

If we played word association here and you heard these words being referred to about some other part of the world, what part of the world would come into your mind when you hear this kind of terminology where a minister, a person in a position of authority, comes forward and says, “By the way, we’re going to change your contract, and by the way, we’re going to pretend that you’ve actually agreed to it, and by the way, we’re also going to take away any right for you to have any recourse”? What part of the world comes to your mind?

Ms Carrick: A very dictatorship type of—

Mr Klees: That’s what this bill is really all about. It’s taking control of the entire health care system, taking it away from community groups, from boards of hospitals, from associations, and putting it into one person’s hand, that being the Minister of Health. You have reason to be concerned. We have reason to be concerned. Ms Wynne goes into her flamboyant way of suggesting the minister will look after everything. One more promise to the people of Ontario, after many that are broken, a trail of broken promises. I suggest this is just one more. We have reason to be concerned.

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Mr Kormos: What’s the status of dental hygienists with this government in terms of their search for a capacity to perform procedures independent of dentists?

Ms Carrick: We are still working with the government and we are hoping that some time in the future dental hygiene will be able to work independently.

Mr Kormos: Have you had any specific meetings since the election in October with the new minister or ministry?

Ms Carrick: I believe we’ve had one meeting with the minister or the minister’s staff.

Mr Kormos: But not with the minister?

Ms Carrick: I’m not 100% sure whether it was with the minister or just with the minister’s staff.

Mr Kormos: Fair enough, because you may not have been there yourself.

Ms Carrick: No.

Mr Kormos: Is the ministry responsive to the goals and objectives of dental hygienists?

Ms Carrick: They have said they are supportive, but they haven’t brought anything forward into the legislation yet.

Mr Kormos: Supportive is good, though. What’s your impression as to what the government is prepared to bring forward in terms of recognizing the role that dental hygienists can play as professionals?

Ms Carrick: My personal opinion is that we’re hoping the government will come forward and remove the order from the Dental Hygiene Act so that dental hygienists can work independently if they so choose, ie, going into long-term-care facilities, working in remote areas and with the underserviced financially poor; working with all those segments of the population to give health care.

Mr Kormos: Have you been told of any time frames that the government expects to work within?

Ms Carrick: No, we have not.

Mr Kormos: What do you want from this government in terms of time frames?

Ms Carrick: We would like sooner rather than later. We will continue to work as long as we have to with the government and hope they will make this change in the Dental Hygiene Act, like they have said they would possibly do if they were elected.

Mr Kormos: Do you think that if dental services were covered under OHIP like other medical services that the government would move more quickly or that even previous governments would have moved more quickly?

Ms Carrick: I’m not sure if they would have or not, because as it stands right now dentistry codes are not under it.

Mr Kormos: Exactly.

Ms Carrick: I’m not sure if they have or not.

Mr Kormos: The reason I’m suggesting that is because if it were an OHIP service, the government would have an interest in ensuring more economical provision of that service, right?

Ms Carrick: Correct.

Mr Kormos: It may well motivate them to respond to the request of dental hygienists in a way that they’re not motivated right now.

Ms Carrick: That is correct.

Mr Kormos: What about the private insurance sector? Surely they have an interest.

Ms Carrick: They do.

Mr Kormos: Where do they stand with respect to the dental hygienists’ position. Our insurer is Great-West Life, which is probably one of the big workplace insurers that covers dental work. Shouldn’t Great-West Life be interested in getting less expensive dental care by utilizing dental hygienists?

Ms Carrick: We have submitted to the insurance companies, and our association has been working quite a few years with the insurance companies trying to work out an agreement. We’re still in the middle of working with that.

Mr Kormos: Where have the insurance companies been with respect to lobbying governments to respect dental hygienists and promote them to the stature they deserve?

Ms Carrick: I'm not sure. I cannot answer that question but I can certainly inquire and get back to you.

Mr Kormos: I'd appreciate that, because I'm not aware of those insurance companies, like Great-West Life, even though they cry all the way to the bank with our premiums—as you know, the insurance industry is just replete with scams and highway robbery syndrome. I'm not aware of them ever rising to the occasion and coming to the plate for dental hygienists and it would seem to be in their interest to do so. Thanks for coming today. I appreciate it.

The Vice-Chair: Thank you very much. We appreciate your coming down. Have a good afternoon.

BRIDGEPOINT HEALTH

The Vice-Chair: Next we have Bridgepoint Health, if you'd like to come up to the table. You have 20 minutes to use in whichever way you'd like. Any time remaining after your presentation will be split between the three parties.

Mr Robert Carman: I know I'm not on the mic, but just to let you know there is a document that we are circulating. I will not speak to everything that's in the document. I will hit some of the highlights and you will see some sections that I will not cover at all.

Chair, I'm here today as the vice-chair of the board of Bridgepoint Health, which is the only integrated network of hospital, community and research facilities in Canada dedicated entirely to medical care and rehabilitation. I'm also here as a member of the public.

We appreciate that Minister Smitherman did indicate in his remarks to the committee that he's prepared to table amendments, and in fact we've seen some of the amendments that have been tabled—they've been circulated by the Ontario Hospital Association—and we very much look forward to continuing this dialogue once we've reviewed those amendments—not just the ones that are presently here, but all the rest of them that we anticipate are going to be coming forward.

Notwithstanding our support of the government's attention to the principles of universal public health care, Bridgepoint Health has significant concerns with, and therefore cannot support, the current draft of Bill 8.

We have four overarching concerns and I just want to give you a quick highlight of those.

First is the shift away from health care as partnership with providers. I would like to say the partnership approach evidenced in the voluntary governance of hospitals has led to significant capacity for community participation in, and support for, hospitals.

Hospital boards provide significant stewardship and leadership for what has been characterized as one of the most complex businesses in the world. Not only do they do that competently, but because they do, whole com-

munities support their hospitals in ways that would not otherwise happen. Local government provides the impetus for the community's support of hospitals in fund-raising and other volunteer roles.

Hospital boards and hospital foundations contribute billions of dollars to research, capital and other initiatives that improve the health of Ontarians. The bill does not appear to recognize that.

The provisions of Bill 8 create a system focused on demands by the funder—government—of the providers, without opportunity for dialogue or collaboration. We question whether any system designed for the public good could operate effectively and in a sustainable way when the balance of power is shifted so significantly in one direction.

It has created a feeling of lack of value for voluntary governance and raises serious questions about its continued role and function, especially in relation to the accountability segments of the bill.

Having said all this, I listened to the minister at lunch today and, as Ms Wynne said, he spoke in very glowing terms about collaboration. What I find difficult to understand is why on the one hand he would be so committed to those principles and on the other hand the bill would not reflect those principles in its initial drafting.

My second point is the lack of synchronization with existing accountability initiatives and mechanisms. Over the last several years, health providers, often in partnership with the Ministry of Health of Long-Term Care, have established a number of mechanisms that augment accountability and transparency in the provision of health services. The paper gives three examples—I'm not going to go into them, but I'm sure most of you know them well—the Canadian Council on Health Services Accreditation; the hospital report card, which is a real milestone in co-operation among players in developing a transparent performance report; and performance contracts for multi-year funding with the joint policy and planning committee.

Our third point was privacy, and in the interest of time, I am going to leave that one; you already dealt with it in the prior submission. I'm also going to leave the fourth point, punitive approach and penalties, because it really refers specifically to the accountability provision, which I want to discuss in greater detail later.

1550

In terms of the Ontario Health Quality Council, in spite of its intuitive appeal, we have a number of reservations around which we would urge further consideration. The first is membership. I know that other hospitals have already covered this, and I'm not going to go into it in detail but just remind you that there is that concern.

In terms of mandate and authority, Bill 8 limits the council's authority to monitoring the system and reporting, with the ability to make recommendations to the minister only in the context of future areas of reporting. That seems strange to us. It seems as if the council only has half a job. Why can't it make recommendations to the minister in terms of what it has learned?

Third, on clarity of metrics, while the Ontario Health Quality Council is welcome, it will only be effective if it has clear accountability for ensuring that it meets the government's objective, which is ensuring that Ontario upholds its commitment to the principles of the Canada Health Act. This can only be accomplished in the context of clearly articulated targets and benchmarks that the government is willing to commit itself to, in areas such as funding, wait times, access to services, number of health professions and services per population segment and population health.

Our fourth point on the council is the relationship to other bodies. The council risks overlap of responsibility and the risk of duplication of efforts with other initiatives and bodies already in place. I've already mentioned some of these.

I'd like to move on to the accountability section, which is the area we have the most significant concerns with. I want to say at the outset that Bridgepoint Health understands the intent of the accountability section of the bill, and we're fully supportive of the principles of accountability.

I should tell you that in my 30-year career with the Ontario government, I was responsible, after the committee on government productivity, for implementing accountability in the public service. So it would be entirely inconsistent with what I did with the Ontario public service if I said anything other than that I was totally committed to accountability. I worked my entire career on it and ended it, as secretary of the cabinet, with performance agreements with all the deputies. So I'm fully committed to accountability; I think it's absolutely fundamental. However, as currently drafted, we believe the bill is seriously flawed and inconsistent with the principles of good governance.

First of all, in terms of the mismatch of accountability and organizational control, Bill 8 places significant emphasis on the accountability of health resource providers in areas that are often outside their control. The definitions of the scope of the accountability agreement in section 19 are very broad and can include one or more of performance goals and objectives respecting roles and responsibilities; service quality; related health human resources; shared and collective responsibilities for health system outcomes; consumer and population health status; value for money; consistency; and other prescribed matters. A number of these elements are partly or significantly outside the control of an individual health care provider, notably consumer and population health status and accessibility. Bill 8 provides no requirement for corresponding commitments by the government to provide the resources to address these various elements of accountability.

Second, the principle of negotiated agreements: Given that accountability agreements are a cornerstone of the accountability provision of this bill, they warrant special attention. Bill 8 extensively references the notion of contracts. However, contrary to the very nature of contracts and contract law, Bill 8 envisions contracts that are unilateral prescriptions from the government to the health

provider. No agreement can be valid unless it's entered into freely, and this is not contemplated here. Few leaders—volunteer trustees or senior executives—would be attracted to a leadership relationship that is so unilateral.

Third, duplication of the Public Hospitals Act: As noted in the previous section, we're concerned that a number of the proposed mechanisms may duplicate or contradict other accountability mechanisms that are already in place, most notably the Public Hospitals Act. We believe this act already provides for appropriate accountability mechanisms and sufficient authority for the minister to act in the case of non-compliance. However, it also requires the minister to always act "in the public interest," and the omission of this in Bill 8 is not acceptable.

Fourth, accountability and good governance: The notion of dual accountability of the CEO, and potentially of other senior executives, runs contrary to any reasonable standard of good governance and essentially makes voluntary governance redundant. More significantly, the burden of these one-sided contracts and the punitive nature of the provisions will substantially reduce leadership's capacity to focus on the day-to-day operational demands of running a health care system. We think that providing absolutely first-class health care is our first responsibility, and we see that these onerous requirements could interfere with that. We seem to be headed toward our own Sarbanes-Oxley, and I don't need to tell you what that has done to companies in the United States.

Finally, in the area of compensation and job security, the language of Bill 8 presumes to supersede any employment contract an executive might enter into with a health care organization. The provision neutralizes the ability of any health care organization to meaningfully negotiate an employment contract and significantly reduces the attractiveness for leaders in entering health care relationships at all.

Fifth, compliance directives and penalties: Bill 8 should also be amended to require that any compliance directive issued by the minister must also be in the public interest, as is required when a supervisor is appointed or when directions are issued under the Public Hospitals Act. We believe that the penalty provisions of the bill are inconsistent with the principles embodied in the Public Hospitals Act that volunteer board members should not be held liable or be subject to actions if they are acting in good faith. The bill should be amended accordingly.

We would urge the government to allow the development of health care funding and performance agreements and the requisite monitoring tools to continue in a collaborative manner under the auspices of the joint policy and planning committee. It's already underway; we believe it ought to be continued under the JPPC. We would also suggest that to the extent there is need to further formalize this accountability, this occur through regulations and not through Bill 8.

In conclusion, the intent of Bill 8 is admirable; however, we believe its methods are flawed. It seems to us

that choices we make today will also decide the future of voluntary governance and health care in Ontario. Bridgepoint Health is committed to achieving the highest standards of excellence in serving individuals living with complex illness and disability. We are proud of the progress we've made in raising the bar on our performance and the evidence that we can now produce on improved outcomes, improved staff satisfaction, improved patient and family satisfaction and a strong balance sheet. We embrace the government's commitment to building a health care system that is accountable, transparent and able to meet the needs of Ontario residents. However, we believe it must be built as a partnership of providers and government. We look forward to being an active partner with the government in achieving the important goal of quality health care for Ontario residents. Thank you for providing Bridgepoint Health with the opportunity to share its perspective with you. We look forward to seeing this bill substantially amended and enhanced as a result of these hearings.

The Vice-Chair: Thank you. We have six minutes, so a very quick question from each party. We'll start with the official opposition.

Mrs Witmer: I had to think when I first saw the word "Bridgepoint." I thought, "Who are these people?" Then I saw the faces and I realized. Welcome, and thank you very much for your comprehensive presentation.

Like many other presenters today, I think you've indicated that although the government is probably well-intentioned and has a commitment to medicare, unfortunately the accountability provisions are extremely troublesome. We've heard from people that they demonstrate a shift of power away from boards to the minister. As a result, there is a fear that over time boards would only become advisory and the accountability you would hope for and the input you'd have from the public would totally disappear. There was even a suggestion today, and you might want to comment, that once you get rid of boards as they currently exist and the governance structure we have, we could see more political influence by MPPs in communities. I don't know if you've thought about whether that's a possibility.

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Mr Carman: Ms Witmer, the question you raise regarding the political involvement is one that we have not discussed. Our concern goes much more to the enormous contribution that volunteers make, not just on the board but volunteers who work in the hospital, and people who give not just of their time but of their money in support of what they consider to be good causes. Our anxiety is that if the governance structure becomes weakened as a result of accountability relationships that go beyond dealing with the corporation, we feel that could have far-reaching impacts in terms of the willingness of the community to view the hospital as its own. Mariah, Do you want to add to that?

The Vice-Chair: You have about 15 seconds.

Ms Mariah Walsh: While we haven't talked about it extensively, it would seem to me that the outcome that

you suggest would be inevitable. Clearly, if there are not voluntary boards who are accountable for the delivery of service, then the government becomes directly accountable for the delivery of service and, I guess by virtue of that, the MPPs who form the government.

Mr Kormos: Thank you, folks. I share with you your passion for accountability, but I put to you this: In the case of a public, community-based hospital, and knowing how boards get selected currently and have been for a considerable part of hospitals' histories, isn't a truly accountable board one which is elected, for instance at the same time as municipal councillors and board of education trustees are elected? Isn't that real accountability, beyond even the level of accountability you speak to now?

Mr Carman: Mr Kormos, one can't disagree with that concept, as you put it. If you're going to make the thing completely and utterly public, why not? Certainly I would never hesitate to put my name up for election for that kind of board.

Mr Kormos: Go ahead. I'm interested.

Ms Walsh: I guess the only additional response or comment with respect to that would be that it really just depends on who the government sees as the ultimate holder of accountability to the public. I mean, is the board of a hospital directly accountable to the public through an elections process, the public that will then judge their performance? Or is it the will of government to have the board of a hospital accountable to the public through the minister and through the Legislature and through that broader electoral process? It's really a choice of who it is the government would ultimately like to see hospital boards held accountable to.

Mr Kormos: Thank you kindly.

Ms Wynne: Thank you for your presentation. You have looked at the framework of the amendments. They are not written in stone. But you understand that in terms of framing the accountability agreements, the amendments are designed to make that a more collaborative process. I hope that when the language is out, you'll be able to look at them and comment further. I hope you will, because you obviously have a lot of experience in this area. Mr Duguid has a question.

Mr Duguid: It's actually more of a comment. I enjoyed your presentation. In particular, I've had an opportunity to review the speech the minister made this afternoon, and there are a lot of commonalities between your presentation and what the minister said. You outline key priorities as being reduced waiting lists, improving access to family physicians and making Ontario healthy. Some of the strategies involved in that are creating a culture of improved accountability and gearing toward improved outcomes. But that's not going to happen easily. It's going to require some very targeted accountability pieces within our process. That's really what the goal of this is in terms of the accountability.

I've served on a hospital board for nine years, up until last year. I can tell you that most of the people I've served with welcome greater accountability and they

certainly welcome the changes to the system, because it's a very frustrating system to work within right now, not geared to outcomes as much as it should be.

So I guess my comment to you is that I wouldn't fear so much some of the rhetoric you are hearing about this being draconian. The measures in here are used only in those extreme circumstances when we run into a rogue board or an organization that does not comply with our goals, which are accountable and agreed to by the people of Ontario as well as boards such as yourself.

The Vice-Chair: Time has run out. I would like to thank Bridgepoint Health for presenting today. We certainly appreciate your coming down, and have a good rest of the afternoon.

CANADIAN CYSTIC FIBROSIS FOUNDATION

The Vice-Chair: Next we have the Canadian Cystic Fibrosis Foundation, who have been patiently waiting at the back. I believe you've been around to hear the rules: 20 minutes, and any time remaining at the end to be used for questions from the three parties. If you would state your names for Hansard, we'd appreciate it.

Dr Josée Chiarot: I'm Dr Josée Chiarot. I'm the director of the medical, scientific and community programs at the Canadian Cystic Fibrosis Foundation. With me today is Jacqueline Romano. She's an adult with cystic fibrosis. I will be speaking for a few minutes and then Jacqueline will be speaking about her life, how she deals with cystic fibrosis and the importance of access to quality CF care and pharmacare. A copy of my speaking notes is included in the package that has just been distributed.

We would like to thank the standing committee on justice and social policy for the opportunity to speak to you today. First, I would like to take some time to talk about cystic fibrosis, or CF, and to provide some background information about the Canadian Cystic Fibrosis Foundation, our work and commitment to high-quality CF care. Then I will make comments on the Commitment to the Future of Medicare Act.

Cystic fibrosis is the most common fatal genetic disease of young Ontario residents. CF affects principally the lungs and the digestive system. In the lungs, where the effects of the disease are most devastating, CF causes increasingly severe respiratory problems. In the digestive tract, CF often results in extreme difficulty in digesting and absorbing adequate nutrients from food. As improved therapies have helped to address some of the malnutrition issues in CF, virtually all CF deaths are due to lung disease. According to the foundation's Canadian patient data registry report from 2001, there are 1,167 individuals with cystic fibrosis attending CF clinics in Ontario and 3,390 individuals with CF attending CF clinics across Canada.

The foundation is a national, non-profit, voluntary health charity that was established in 1960. We have vol-

unteers across Canada in 52 chapters, and 19 of these chapters are in Ontario.

Our mission is to help individuals with CF, and we do this by funding research toward the goal of a cure or effective control for cystic fibrosis, supporting high-quality care, promoting public awareness of the disease and raising and allocating funds for these purposes.

In 2003-04, the foundation has committed over \$5 million in support of CF research and over \$1.8 million in support of CF clinical and transplant programs, for a total medical and scientific program budget of \$6.8 million, of which \$2.8 million is spent in Ontario.

Since the foundation was established over 44 years ago, the median survival age of young Canadians with CF has increased from four years of age to almost 36 years today. As a result, the biggest change we have witnessed over the course of our history is the very dramatic growth in the size of the Canadian population of adults with CF. It is anticipated that in the next few years the number of adults with CF across Canada, including Ontario, will surpass the number of affected children for the very first time.

We feel it's the responsibility of governments to ensure that basic, underlying support to individuals with CF in the form of medical and hospital services are provided by the government. In 1960, there were virtually no specialized clinical services for individuals with cystic fibrosis and about half of all children born with the disease died before reaching school age. Since that time, the foundation has successfully pursued the creation of cystic fibrosis clinics. Today there are 37 clinics across Canada, 11 of which are in Ontario. In these clinics, multidisciplinary teams of health care professionals with specialized knowledge of CF provide the finest care available anywhere in the world.

The foundation is committed to the protection and ongoing enhancement of team-based collaborative clinical services for CF and to extending the range of options available to the CF community. The foundation's clinic incentive grants are designed to enhance the standard of clinical care available to Canadians with CF by providing supplementary support for clinical personnel and for ongoing medical and professional education, with the overall goal of optimizing health for everyone with cystic fibrosis.

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Another important development has been the movement to establish outreach clinical services for children and adults with CF. Some affected individuals live a considerable distance from the nearest specialized CF clinic and one of the foundation's objectives is to provide financial support for outreach services, enabling physicians and other health care professionals from established centres to travel to outlying areas to provide care for those individuals with CF.

As part of our clinic incentive grant program, the foundation conducts a clinic site visit program. This program involves a peer review process that provides an opportunity to observe the policies and services being

offered at each clinic and also enables an exchange of information among clinics, ensuring that CF care in Canada remains of the highest calibre.

All CF clinics participate in the collaborative undertaking of the foundation's Canadian patient data registry. The purpose of this registry is to identify and track statistical trends within the CF population, thereby providing an accurate profile of CF in Canada, to generate questions which can be addressed through research and to contribute to improved clinical care and eventually to the discovery of a cure or control for CF.

With data from the registry, it is possible to calculate the median age of survival, which is currently 35.9 years—the highest ever. It's also possible to compute hospitalization rates, and the data have been used to demonstrate decreased hospitalization rates over the past few years. It has also been demonstrated, using the registry, that most cases of CF are now diagnosed in the first year of life, which is crucial in ensuring that treatment programs are begun as early as possible. The response to improvements in nutritional care can also be monitored. The registry has helped the Canadian CF medical and research community remain at the forefront of CF care in the world.

In addition to high-quality care, affordable drug costs are a key element of increased life expectancy and quality of life for patients with CF. While the provincial special drugs program has endeavoured to create an environment of affordable access to necessary, life-sustaining drugs and nutritional supplements, the cost of medications remains a major concern for individuals and families. Annual medication costs for young persons with CF vary; however, they can be as high as \$30,000 a year. The foundation believes that all children and adults with CF should have equitable and full access to life-sustaining drugs. Decisions regarding the use of medications for individuals should be based upon the best medical judgment of the physician or specialist, in consultation with the patient, not on the ability of the patient to pay for those medications.

The financial burden of CF is most acute in the adult CF population, where a number of adults with CF are not accessing the drugs they need due to out-of-pocket costs. Many of these young adults work in lower-paying, entry level positions, without extended health benefits. For many, access to publicly funded drugs and nutritional supplements means the difference between being productive members of the community or becoming dependent on social services. Because of the disabling effects of CF, many adults with CF work part-time, without supplementary medical benefits, or are simply unemployed.

Unfortunately, many CF drugs are very expensive. As our understanding of this multi-system, multi-organ disease increases, so does the cost of treating it. The bottom line is that we also have an increasing number of young adults who, with adequate health care, can make useful contributions to our society. Almost 50% of individuals with CF in Ontario are over the age of 18. This impressive statistic keeps increasing and this is a

testament to the excellent level of care received by CF patients and significant improvements in available drug therapies.

The foundation was pleased that the government of Ontario confirmed its commitment to the fundamental principles of medicare as laid out in the Canada Health Act: public administration, comprehensiveness, universality, portability and accessibility. We were encouraged by the government's action in announcing the Commitment to the Future of Medicare Act.

The foundation believes all young Ontarians with CF should have access to high-quality CF care and medications, regardless of where they live in Ontario and regardless of how much money they earn. With an increasing population of Ontario adults with CF, future access to high-quality CF care and life-sustaining drugs is vital to sustain these individuals.

In reading the proposed act, however, we are concerned that it only addresses pharmacare and home care in the preamble and nowhere else in the act. As these are critical to young Ontarians with CF, we believe they should be addressed within the act.

The foundation and the CF community have shown leadership and commitment to high-quality CF care in Ontario through our research programs, peer review clinic site visits, the registry and dedicated volunteers and health care practitioners. The government of Ontario has also been a leader in supporting the treatment and care of persons with CF.

However, we have learned of persons with CF not taking prescribed medications, or limiting the amount they take, because of cost, and of situations in which a certain drug, although it would be beneficial to the patient with CF, is not prescribed, because patients simply do not have the means to pay for it and it's not otherwise available to those patients.

This past year, we have learned of situations in Ontario where persons with CF waiting for a lung transplant were denied available lungs as there were no ICU beds available. For many individuals with CF in Ontario and in Canada whose lungs are severely damaged because of chronic infection, a lung transplant represents the only means of survival. Candidates for transplant who wait in various stages of precarious health should not be denied the opportunity for possibly renewed health and longer lifespan because there is no physical capacity for the surgery, despite an available organ, a willing recipient and a willing transplant team. We hope this problem has been resolved with the opening of an expanded ICU facility at the University Health Network.

A commitment by Ontario to provide continuing and extended coverage for CF medications and access to high-quality CF care will bring tremendous advantages to the province, as well as to those affected. The benefits are enormous. You will be keeping individuals as functioning, active members of society: going to work; going to school; participating in social activities; and otherwise contributing to the fabric of the community and the country.

Lack of access, or a reduction in access, to essential and indeed life-sustaining treatments and medications will certainly lead to devastating consequences for young persons with CF. It could also result in higher costs to the health care system with increased hospitalization rates for persons with CF.

It is, of course, much less expensive to maintain an individual at home, and indeed in the workforce, with medication and other supports than to have the individual occupy a very expensive hospital bed. Daily costs for a hospital bed and related treatment for someone with CF far exceed the monthly medication bill for most individuals. It is obvious that maintaining an individual as a functioning member of society will pay dividends to society.

Young Canadians with CF and their families should not be plagued with extensive disease-related out-of-pocket expenses. Fighting CF is hard enough. Diagnosis of a life-threatening genetic disease should not translate into a lifetime of personal financial hardship as a result of one's illness. As the Minister of Health and Long-Term Care has stated, Ontarians should have access to "health care services based on need, not ability to pay." We encourage the committee and the Ontario government to make a commitment to the future of young persons with CF by making a commitment to continued, accessible and enhanced high-quality CF care and pharmacare in Ontario.

I would like now to ask Jacquie Romano to say a few words.

Ms Jacqueline Romano: Thank you, Josée.

Good afternoon, committee members, ladies and gentlemen. Thank you for allowing me to speak to you this afternoon. I'm grateful for this opportunity, because I am one of over 1,000 Ontarians with CF and I am speaking on their behalf as well as my own.

As I appear here today, I may not appear sick or struggling with a deadly disease. However, the average age of a person with CF is now just over 35, and if I were to be average, I have just over two years to go. I am one of the lucky ones. Many of the people with CF that I know today are on oxygen 24 hours a day, are doing up to six hours a day of physiotherapy simply to maintain their lung function, have feeding tubes in their stomachs simply so they may have adequate nutrition to live, or are waiting for a lung transplant, which is their only, final hope. Most of the other people with CF I have met over my life are dead. I am one of the lucky ones.

CF is a genetically inherited chronic disease affecting mainly the lungs and digestive system. In the digestive system, pancreatic enzymes do not reach the area they need to in order to process nutrients, so I need to take enzymes with everything I eat in order to digest the nutrients. In my lungs there is chronic infection, which causes scarring, sometimes bleeding, and a chronic cough. Bit by bit my lungs will be destroyed despite aggressive antibiotic therapy, and I eventually will succumb.

However, I am one of the lucky ones. Most of my life-sustaining drugs are now paid for by the government, due to their catastrophic costs, and my frequent hospital visits have become less frequent due to access to home care. As a result, it gives me great hope that, in his remarks to this committee, the Minister of Health and Long-Term Care, Minister Smitherman, explains that the government believes, "that the health system is the whole of its complementary parts. It was anchored on the foundation of hospitals and physician services, but to be relevant it must evolve to encompass a full continuum of care including primary health care, home care, and pharmacare." Primary health care, home care and pharmacare, those three things, impact my life greatly and are indeed the elements that have given me such good health.

1620

Primary health care: I was diagnosed a few months after birth right here in Toronto by a CF specialist named Dr Crozier at the Hospital for Sick Children. Because my birth mother was young and lived outside the GTA, she would not be able to provide the hours of special care that I required, nor the regular trips to the CF centre in Toronto. I was put up for adoption, and adopted by a family that was committed to hours of physiotherapy and a strict regime of enzymes and other drugs. When they adopted me, my family did not expect me to live long enough to attend school. Three times a day they ensured that I did an inhalation mask and had chest clapping to loosen the mucus in my lungs and help prevent infection. Every three months, my mom and dad brought me from Guelph to Toronto to attend the CF day clinic, where I was monitored by a team of specialists.

Because I was diagnosed at such an early age, had such dedicated parents and because I was followed by the CF team of specialists, I did well and remained fairly healthy. When I was 12, I was admitted to hospital for the first time for a lung infection. This included a two-week stay at Sick Kids to receive antibiotic therapy to limit the damage done to my lungs. During that hospital stay, three other people with CF died on the floor, and I was sure I was going to be next.

My parents visited on the weekends, but the time in between their visits was almost interminable. These two-week stays became more frequent as I got older, and I now refer to them as a tune-up. In the last 10 years particularly, it has become increasingly difficult to obtain a tune-up because of the lack of availability of hospital beds. Because my infection is chronic and not necessarily acute, I often have had to wait a few weeks before a bed would become available. While this wait has never been life-threatening, infection causes lung damage, and the longer you wait the more damage is done.

It is critical that the government continue to support primary health care in this province so that people with CF can be diagnosed at an early age, receive the specialist care that prolongs lives, and have access to hospital beds when they are required.

It was during a time of too few hospital beds that I became acquainted with the second branch of health care,

that is, home care. I was waiting to get a bed in the hospital but needed antibiotics urgently as I was coughing up blood, had a fever and a raging infection. Rather than go into the hospital for the stay, my CF nurse coordinated with the home care provider to have my IV meds done at home. Since I was already heavily involved with self-care and had been to the hospital numerous times for a tune-up, I was fairly familiar with the regime that I would undergo at home. The nurse arrived at home, put in an IV line, hung the drugs and outlined the schedule I would need to follow. There was a 24-hour pager number to call if I needed help or ran into problems, and the nurse would visit me daily to ensure things were going smoothly.

There are a number of benefits to having home care available to those who can use it: It saves much-needed beds in the hospital for non-acute patients who are either able to look after themselves or who have adequate home support to follow the regimes. It was far less stressful on me as a patient, since I was at home with my familiar surroundings and routines yet still getting the critical therapy. Finally, sometimes I am able to continue working part-time while on IV therapy, going to work between doses and remaining a productive, taxpaying member of society.

There are, however, a number of snags in the home care system. I must take my first antibiotic dose under the supervision of a nurse in the hospital in case of any adverse reactions. A better process is needed for initiating the IV therapy as an outpatient service, but funding is too tight. There is also a need for more IV pumps in the community. When I first started doing home care, I was advised I couldn't have a pump, since there were only two pumps available in the area and both were being used. At several thousand dollars each, no more could be purchased for the program to use. This meant that each time I hooked up to my IV for a two-hour dosage, I had to monitor it constantly to ensure the line was not crimped or the bag was not empty. This is particularly difficult to do into the night, trying to remain awake long enough to monitor the IV line.

It is inconveniences such as these that make all the difference to a person who is sick and in need of rest and can help that person decide against using home care in the future. By ensuring adequate funding and improving support to the home care system, many dollars can be saved while still providing the top-notch health care that Ontarians deserve.

Finally, pharmacare is the third branch of health care that is of utmost importance to people with cystic fibrosis. As Josée has explained, the cost of drugs for a person with CF is staggering, and we would not be living as long as we are without those drugs.

The Vice-Chair: There is one minute left in your presentation.

Ms Romano: So when the Minister of Health and Long-Term Care states that the health system must evolve to encompass a full continuum of care, including primary care, home care and pharmacare, he has my

attention and the attention of everyone in Ontario with CF.

How will the government make good on their commitment to make Ontarians the healthiest Canadians? I challenge you to consider what I have said today and to incorporate at least some of these concepts in the bill.

The Vice-Chair: Thank you very much for your presentation. We have two more presentations this afternoon and we do have two of three—is that the Ontario Health Coalition or—it's Lakeridge. So perhaps we could take a question from each party. I think you made a wonderful presentation here today and I'll start with Mr Kormos. Do you have a question?

Mr Kormos: No, thank you, Chair.

The Vice-Chair: Ms Wynne?

Ms Wynne: I don't have a question. I really appreciate your presentation. Thank you very much for coming. The only thing I want to point out—and it's not in any way meant to diminish what you've said—is in the preamble, the recognition for pharmacare and for home care have been placed there because this is a commitment to the future of medicare. So what we wanted to be sure was that all the components that we recognize are critical were in the document, because there will be future legislation. This bill isn't meant to do everything that we're committed to—it's a first step—but we wanted to make sure that we didn't leave those pieces out, because they have to be there for the future.

Dr Chiarot: Thank you.

Mrs Witmer: Thank you very much for coming. I very much appreciate your presentation. I think it's really important that all of us as MPPs have the opportunity to hear first hand the work that's done by the association and also the impact that cystic fibrosis has on individual lives such as yours. Certainly, you're very fortunate to have had wonderful parents who have supported you.

Ms Romano: Absolutely.

Mrs Witmer: I just wish you all the best.

The Vice-Chair: As Chair this afternoon, I'd like to thank you for your presentation. We certainly appreciate you coming down and presenting this powerful presentation to us. To the committee, we will recess for about five minutes and wait for—

Mr Duguid: Are the other deputants not ready to go?

The Vice-Chair: No. The next group is not here and Lakeridge Health have two of their three presenters here. So we'll take five minutes.

The committee recessed from 1629 to 1636.

ONTARIO HEALTH COALITION

The Vice-Chair: Next we have the Ontario Health Coalition. I would like to welcome you. The basic rules: 20 minutes for the presentation. If you don't use the full 20 minutes then we'll have a question period where we'll divide the time between the three parties. If you're ready, we would be happy to hear your deputation.

Ms Natalie Mehra: The Ontario Health Coalition represents over 400 member organizations and thousands

of individuals across the province. Our mandate is to protect and extend a quality, universal one-tier public medicare system.

It's hard for us to comment on this bill, partly because the title of the act is something of course that we fully support. However, there are key things missing from the bill and we have some problems with the direction of some significant portions of the bill. What I'll do is focus on the recommendations that are outlined in our brief and then allow time for questions.

If we were to write an act about protecting the future of the public health system, we would ensure that included in such an act—not just in the preamble but also in the body of the bill itself—are concrete initiatives to restore the accessibility, comprehensiveness and universality of the system. We believe that we need to see some concrete initiatives to actually apply the principles of the Canada Health Act, although we applaud the inclusion of the principles in the preamble of the bill.

We also believe that privatization poses a significant threat to the future of the health system and that the act should be amended to ban P3 hospitals, return the diagnostic clinics back into non-profit hospitals and stop the tide of privatization that is sweeping across Ontario's health system.

We believe that the health council must be amended to be a democratically appointed body, either through appointments from each of the parties or another democratic system and that it should report on the performance of the health care system with respect to the principles of the Canada Health Act. Its purpose should be both to report on how the health system meets the principles of the Canada Health Act and also make recommendations regarding this.

We believe that the accountability section of the act is actually looking in the wrong direction, that accountability includes the accountability of the health minister to the people of Ontario, not just health care institutions to the health minister.

We believe that if the minister has in mind another attempt to restructure the health system, he should make that clear to the people of Ontario, that the people of Ontario should have the opportunity to debate and discuss this openly and have meaningful input about any restructuring taking place in the health system.

We believe that the bill must be amended to provide accountability of health institutions through democratic control, meaningful public input and consultation, transparency and disclosure, and full whistle-blowing protection for those people who make complaints about the practices of corporations and managers in the system.

The bill must be amended to stop queue-jumping for so-called medically unnecessary services and must include recognition that the delisting of services and the growth in charges for access to so-called medically unnecessary services is becoming a threat to the application of the principles of the Canada Health Act in Ontario.

We also believe that the bill must be amended to stop block fees, ban boutique medicine and extra-billing and to support primary care reform.

On the application of the principles of universality, accessibility and comprehensiveness, we believe that it's imperative that the delisting of medically necessary services be stopped and reversed. For instance, audiology services and physiotherapy services that have been delisted are inarguably medically necessary services and should be covered under the public system.

We believe that the lack of access to primary health care, the lack of access to physicians in the system, means that the Ontario health system actually does not fulfil the principles of the Canada Health Act, and that problem needs to be addressed as quickly as possible; that the supply of health care services should be designed to meet population need rather than short-term financial goals; that the homemaking services that have been cut for 115,000 frail elderly people over the last year should be restored; that access to rehabilitation therapy, speech pathology, physiotherapy and other services like that that are almost inaccessible across the province need to be restored; and that the government needs to take firm steps to move on controlling the cost of pharmaceuticals and assistive devices and access to other treatments.

We believe that the surest way to ensure that we won't have a sustainable medicare system in this province is to hand over the control of that system to private for-profit corporations. We need only to look at the cost in the United States to see that a for-profit health care system costs more. In 1971, when the last province signed on to public medicare in Canada, the United States and Canada spent about the equivalent amount—7% of our gross domestic product—on health care. As of last year, the United States spent 14% of its even bigger GDP; we spent 10%. The record of public health systems in controlling costs is evident around the world. We believe that the trend toward introducing P3 hospitals, private for-profit clinics, private long-term-care facilities, private home care corporations and privatization throughout the operation of the health care system poses a significant threat to the future of the health system not only because it will drive up costs but because it also imposes on the health system the culture of for-profit industries: exorbitant executive salaries, low worker wages, advertising, unnecessary duplication, higher administrative costs, reductions in the scope of services offered under the public system, and both the motive and means for corporations to introduce and grow two-tier health care. Therefore we believe that the P3 hospitals, the MRI clinics, the private for-profit clinics must be stopped.

I've talked about the health council.

Most important to us in this bill are the provisions around block fees, or charging patients fees up front for access to family physicians, and the accountability sections of the bill.

I want to share with you a few stories from across the province. These are complaints that have been received by the College of Physicians and Surgeons of Ontario

about the use of block fees: a psychiatrist charging patients to review their daily logs; patients being told that their physicians would drop them from their practice if they did not pay the block fee; patients told that their telephone messages would go unanswered if a block fee was not paid.

In addition, a recent *Globe and Mail* article describes two family physicians who are charging their patients a \$2,500 annual fee for a detailed medical workup, a customized health plan and 24/7 access. These two physicians are aiming at practices with 150 patients each rather than the usual 2,000 patients per physician. Technically, it's believed that these physicians' practices are not in violation of the College of Physicians and Surgeons' block fee policy, but, called boutique medicine, this practice poses a significant threat to the health system, both in violating the spirit and intent of the Canada Health Act and also in reducing the supply of physicians.

We're hearing now that block fees are being charged of about \$100 across the province and in some places \$200, and recently we heard of \$250 block fees being charged in Burlington.

We support this bill in bringing block fees under the regulation of the government by putting it into legislation. However, we believe that the bill should go further in banning block fees entirely. We believe that they are unnecessary charges, that they violate the spirit and intent of universal public medicare, that if physicians can charge piece by piece for those services it's completely unnecessary to charge for them up front, and it's open to abuse.

Further, we believe that the accountability section of the bill should be repealed and replaced with an accountability section that actually draws the lines of accountability from health providers to government to the people of the province; that we must start to institute democratically elected boards, open memberships in health institutions, diverse representation on those boards; that health care workers deserve and must have whistleblower protection—gag orders are rampant across Ontario; that transparency should be imposed regarding delisting and defunding; that there should be democratic governance of the OHIP list; that meaningful restrictions on commercial secrecy and full public reporting on finances within health care institutions and sectors should be in the bill; that public consultation, meaningful input and public debate about changes in the health system ought to be part of public accountability; that full public disclosure of fees and other out-of-pocket costs should be in the bill.

Notably, we tried to find out what physicians can charge for block fees. We phoned everywhere that we could. Eventually, we found out that we could get the list from the Ontario Medical Association if we paid a fee of over \$100.

We believe that the accountability section of the bill should include a duty of the minister to provide stable, timely, multi-year funding; that representation of diverse

populations, equality seeking groups and geographic diversity should be mandated for all boards of health care institutions; and that meaningful input of health care workers and users should be implemented at all levels. Thank you.

The Vice-Chair: Thank you very much for your presentation. We have about nine minutes left, so three minutes for each party. The government side, Ms Wynne?

Ms Wynne: Thank you for coming and thank you for your sophisticated and knowledgeable presentation. A couple of things: You talk about investigation—the language in the bill is “reporting on”—and there's been a suggestion a number of times that there should be some reporting capacity on privatization. Can you just expand on what you think the council should be tracking?

Ms Mehra: There are a few things. One is that we think it should be explicit in the bill that the council should be reporting on how Ontario's health system measures against the principles of the Canada Health Act—Is it accessible? Is it comprehensive? Is it universal?—and making recommendations regarding those principles and the application of those principles. In addition, we believe that if we could only have access to the information, we would find that the privatization of services across the province is costing us more per unit. It would be helpful if the council would investigate that.

Ms Wynne: OK. So you see the council as a useful body in terms of shining a light on, if not all the things you're asking for, at least on the direction that we're going. In principle, you support the idea of having that council in place. Am I reading you correctly?

Ms Mehra: In principle we support it. However, we believe that it shouldn't detract from the minister's responsibility for ensuring that the Canada Health Act principles are followed. We're also concerned that, as it's presently constituted, it could actually be used by a future government that opposes medicare to propagate reports that are biased against the application of medicare principles.

Ms Wynne: That's interesting, because one of the reasons the council has been articulated or described the way it has been is that the minister does have the ultimate responsibility, and that rests with the government. So what we're looking for is a council that can report on these things but does not take on the power of the minister. That's in line with what you're suggesting.

The Vice-Chair: One minute.

Ms Wynne: OK. There are a lot of questions. Thank you very much. Bob has a question.

Mr Delaney: I have one short question. When you advocate the restoration of access to delisted services, do you mean all currently delisted services?

Ms Mehra: No, we mean medically necessary delisted services. Specifically in the brief we talked about the audiology services and the physiotherapy services that have been delisted. It's actually not possible for us to get a full listing of what's been delisted, because it's not

published anywhere, so we couldn't advocate for that. We don't know what the full list is.

Interjection.

1650

The Vice-Chair: No, time has run out. Ms Witmer?

Mrs Witmer: Thank you very much. You mention in here that you would like improved access to primary health care through primary care reform that includes non-profit teams of salaried health care providers. Could you just explain who would be included, and how would you see those operating? How would that be different from community health care centres?

Ms Mehra: I think it probably depends on the range of the team included in the primary care reform group as to how similar or different it would look compared to community health centres, but community health centres are a good example of that type of model.

Mrs Witmer: OK. Originally, when primary health care was introduced, the intention was that you would expand and you'd have physicians, you'd have nurses, you'd have social workers, pharmacists—the list would go on and on. That's what you are talking about?

Ms Mehra: Ideally, that's what we're talking about, but moves in that direction would be supported by us.

Mrs Witmer: And you support community health centres as well, which is a little bit different concept?

Ms Mehra: That's right.

The Vice-Chair: Mr Kormos.

Mr Kormos: Thank you kindly. With all this talk about accountability, you're the first person coming before this committee whom I have witnessed calling for true accountability, and that is the democratic election of hospital boards of governance. That is what you proposed. I mean, what a novel idea. We've had private members' bills in the Legislature advocating for that. What's the problem? Nobody's hip to the fact that hospital boards are inevitably little cliques? They are, aren't they?

Ms Mehra: I think that they are better and worse in some parts of the province, but the worse ones are self-appointing boards.

Mr Kormos: Incestuous little cliques, right? Rife with backroom dealings. Is that your sense?

Ms Mehra: Our sense is that some of the most powerful hospitals in the province have self-appointing boards so they appoint the membership that appoints the board or they run slate elections that are very undemocratic.

Mr Kormos: Of course, one of the arguments I anticipated was, "You can't have democratically-elected boards because you have to choose people with the right sort of credentials and backgrounds. You've got to make sure people have expertise in that area." That's one of the arguments, isn't it?

Ms Mehra: Yes.

Mr Kormos: Strange how that isn't applied to city councils or to provincial Legislatures or to federal Parliaments, though, isn't it?

Ms Mehra: Exactly.

Mr Kormos: God forbid they should ever require literacy tests of elected members of Legislatures.

The Vice-Chair: Thank you very much for your presentation.

LAKERIDGE HEALTH

The Vice-Chair: Next we have Lakeridge Health. Once again, 20 minutes for the presentation. In the time you do not use up in your presentation we'll have questions. Please identify yourself for Hansard.

Ms Anne Wright: Good afternoon, ladies and gentlemen. My name is Anne Wright. I am the chair of the Lakeridge Health board of trustees. I have with me our Lakeridge CEO, Mr Brian Lemon, and our chief of staff, Dr Donald Atkinson. They should be able to help me in answering any questions you may have.

Today I would like to raise the concerns of my board related to local governance, accountability and accessibility, as well as specific issues related to our rural hospital sites.

While I recognize that the minister has tried to provide some comfort and clarity on some of these issues, unfortunately we have not yet seen the specific language proposed. As a consequence, some of the concerns I am raising today may well be addressed during the redrafting process. However, I still believe it is important to raise our concerns to ensure that they are, in fact, fully dealt with when these changes are considered.

Let me start today by letting you know just who we are. Lakeridge Health was formed in 1998 pursuant to HSRC direction and is one of the largest community hospital networks in Ontario, with four hospital sites, located in Bowmanville, Oshawa, Port Perry and Whitby. Lakeridge Health is distinct among other Ontario hospitals because we serve urban and rural, large and small communities. With over 3,000 employees, the Lakeridge Health system provides a comprehensive range of patient-focused services to over 500,000 residents of Durham Region. On any given day, over 1,500 people come through the doors of Lakeridge Health looking for the quality care they need and expect.

Lakeridge Health agrees with many of the broad goals behind Bill 8, such as: the creation of the Ontario Health Quality Council to monitor and report on important health care indicators for Ontarians; ensuring that the health care system remains accessible for all Ontarians by embracing the five key principles or pillars of the Canada Health Act; and by adding accountability as a sixth pillar, entrenching accountability as a central principle in Ontario's health care system by establishing accountability agreements that set out clearly established, negotiated and agreed to performance measures. We agree with all of that.

Lakeridge is accountable to the Ministry of Health and Long-Term Care under the Public Hospitals Act and abides by the strict directives outlined by government, including the public disclosure of all financial information.

The Lakeridge Health board of trustees is also accountable to its patients and the community it serves in a variety of different ways. Whether it be better use of taxpayer dollars, balancing the budget, acting on community concerns or simply keeping the community informed, we take our responsibilities seriously.

Like other hospitals across Ontario, this dual accountability helps to ensure a balance between the concerns of the minister and the community. This, however, can occasionally create a dichotomy between community expectations and ministry funding capability.

We are particularly concerned, however, with the provisions contained in Bill 8 that will undermine community-based voluntary hospital governance. Specifically, Bill 8 allows for the imposition of accountability agreements without negotiation or agreement. The government would effectively undermine the current check and balance that ensures the community has a voice in the health services they receive and how these are managed. We would like to see more clarity regarding the minister's February 19 commitments relating to notification prior to the minister or the ministry unilaterally directing changes to health services provided by the hospital in the community.

Notwithstanding the minister's clarifications issued on February 19, Bill 8 would still allow the minister to direct and/or penalize a hospital CEO, effectively altering or removing from the board its powers to determine CEO terms of employment under the Public Hospitals Act. Responsibility for negotiating and enforcing accountability agreements should remain with the board and the government. Responsibility for ensuring that a hospital CEO lives up to that agreement should rest completely with the board, not the ministry.

The CEO and chief of staff are the only direct board employees and are therefore accountable to the board. Whether by threat of penalty or by direction, Bill 8 provisions related to the CEO still appear to clearly usurp the role of the board, while placing him or her in the unenviable position of having potentially two masters with differing priorities. The Lakeridge Health board commits to you that we will continue to fully hold both the CEO and chief of staff accountable for performance.

It is important to remember that accountability in the hospital sector is not a one-way street. For hospitals to become fully accountable, government—our major funding partner—must also shoulder its accountability responsibilities, particularly as it relates to stable funding.

Over the years, working together, government, hospitals and the OHA have forged close working relationships in order to fulfill our obligations to the health care system. Hospital report cards and work on multi-year funding and accountability solutions are just a few examples of the benefits of collaboration. They illustrate clearly that by working together in partnership on behalf of Ontarians, we are all truly better together.

The tone of Bill 8, as it is currently drafted, does not support the spirit of collaboration that is necessary to advance health care, nor does Bill 8 provide for appro-

priate reciprocal responsibility on the part of government, hospitals and other health care providers.

We are supportive of the government's directive to move from providing expensive hospital-bed-based services to outpatient services where these have been shown to be appropriate and maintain or improve patient access and quality of care. However, Bill 8 fails to define key terms such as "accessibility," "medically necessary services," "quality" and "comprehensiveness," nor does it provide for guaranteed waiting times to ensure that the system is accountable to patients. Without clear definitions in Bill 8, we will continue to struggle to provide the perceived needs and expectations of the community and the much increased needs of the acute care sector. For example, what are the core and non-core clinical services hospitals are mandated to provide?

The Lakeridge UV clinic—which is ultraviolet—is a case in point. We have provided this service because these patients see it as an important part of their treatment. However, there is little evidence of its efficacy, and these services are also available elsewhere in the community. In the case of the UV clinics, it is clear we should discontinue the service. However, there are many more issues where it is less clear. With tightened funding and increased accountability, boards now have to look at possible changes to some services without the clarity necessary to determine whether they are considered core clinical services and can meet the test of the Canada Health Act.

1700

To enhance the ministry-hospital accountability relationship, multi-year funding commitments are a critical necessity in making real improvements in long-term accountability. I have just received a copy of the minister's comments from today, and he does talk about predictable funding. I hope it is targeted at this issue. If so, we would definitely welcome that as an initiative.

From a review of Bill 8, it would appear that many of the government's accountability concerns are currently being addressed by the multi-year funding and performance agreement task force of the joint policy and planning committee. Bill 8 currently makes no provision for multi-year accountability and funding agreements.

Ontario hospital boards understand the need to ensure prudent fiscal management and accountability; however, there are ministry funding issues that also need to be addressed to allow us to appropriately discharge our accountability responsibilities and balance our budgets. While we wait for multi-year funding, we continue to operate in a sea of funding uncertainty. No organization can plan and operate efficiently without knowing what its budget will be.

Additionally, all too often hospitals are not given their operating budgets until well into the fiscal year. At Lakeridge Health, for example, despite the fact that we are obligated to plan for the coming fiscal year, we have not yet been given our revenue budget. In previous years, budget notification has varied dramatically and has always been received long after the planning period and

often well into the fiscal year. So as you can see, for a year beginning on April 1, for the last five years we have received notification of our revenue budget on April 14, September 26, September 28, June 28 and August 1. This means that more dramatic cuts must be made if a board wants to balance its current-year budget, and given the terms of collective agreements, it can take six months or more for a hospital to make necessary adjustments.

While these issues are problematic for all hospitals, they are especially so for rural sites where, due to their small size, budgetary surprises can be devastating or make it impossible for those hospitals to adjust to revised budgets.

The board of trustees of Lakeridge Health is committed to and accountable for ensuring appropriate access to quality health services to both our urban and rural communities. As a hospital system with a strong rural element, it is important to note as strongly as possible that Bill 8 is troubling. For example, while we believe in accountability, the provision of care in rural and/or remote sites can be both more difficult, perhaps because of a lack of physicians, and more costly, because we may be resourcing essential services even when patient volumes are low.

The unique circumstances faced by rural hospitals limit our options for reducing costs or finding economies of scale while need demands that we continue to provide many of these necessary services. This is why Lakeridge continues to advocate for appropriate financial and medical resources on behalf of our rural citizens. It is also why the board recently approved the creation of a rural health training institute, to be located at our Port Perry site.

However, by removing the requirement for the minister to act in the public interest, as defined by the Public Hospitals Act, the minister is less accountable to the public in ensuring accessibility to health services in the community where the hospital is located. Coupled with the prospect of forced accountability agreements, this opens the door for a potential weakening of accessibility and is of particular concern for rural facilities.

Lakeridge Health is also extremely concerned that one of the consequences of Bill 8 is the potential for decreased accessibility in a number of other ways. The lack of clarity around section 9 is of major concern to our rural sites in particular. Specifically, we are concerned as to whether this section might prohibit current practices such as incentive recruitment bonuses, locum coverage or guaranteed income agreements necessary to recruit and retain certain medical specialists.

We are also concerned that we have not yet seen the proposed changes to section 9. While the minister has undertaken to allow for payments to hospitalists, lab physicians and other specialists who currently receive direct payments from the hospital for work such as providing on-call services, we feel it is nonetheless important to reinforce the need for this change in section 9. In addition to reducing access, disallowing these payments will eliminate the many proven benefits derived, while inadvertently raising costs and reducing efficiencies.

The Lakeridge Health board of trustees unanimously believes that Bill 8 in its current form will not achieve the goals of ensuring accessibility and accountability, because it undermines the role of community voluntary governance of public hospitals. The bill, as currently drafted, may in fact limit accessibility, particularly for Ontario citizens residing in smaller communities. We believe that working together to improve accountability and access is the preferred approach. Together, not only have we made impressive strides over the years, but Ontario and its hospitals are also leading the way on accountability.

As proof of our commitment to improving accountability and accessibility, all Lakeridge Health board of trustees have affixed their signatures to this presentation, with the exception of three who were absent and we were unable to get theirs. However, they are in full support of the presentation.

The Vice-Chair: We have about nine minutes remaining, so three minutes for the official opposition.

Mrs Witmer: Thank you very much to Lakeridge Health for being here today and sharing your concerns. Your concerns in many ways echo what we heard last week and this week. Despite the fact that the government wants to improve accountability and access, it appears that as people have done their analysis of this particular piece of legislation, it has the impact of doing exactly the opposite. You speak specifically about the fact that it's going to limit access for people in small communities. You've talked about locums, incentive recruitment bonuses and what have you. Is that what you mean when you talk about the fact that it's not only going to limit access but in particular it will have a more severe impact on small rural communities?

Ms Wright: Yes. Rural communities particularly have difficulty recruiting primary care physicians but specialists as well. Even to recruit primary care physicians, it's a general practice that there are certain recruitment incentives paid to physicians in order to get them to come to your community. I'm not quite sure how this legislation would affect that, but if it does affect that, then it would severely limit our ability to recruit physicians.

Mrs Witmer: We've certainly heard from physicians that because of the content of this bill and some of the provisions, they would consider leaving the province as well, particularly new physicians who obviously don't want to be bound by some of the provisions that are contained therein. So it certainly appears to have the impact of reducing accessibility to health care services even further than is presently experienced.

The other issue is accountability. Again, there is tremendous concern that the role of the local board of a hospital is going to change. Obviously with the minister having more power and the shift in power, the hospital board will be no more than an advisory board. If that's the case, what do you think is going to happen to the people who currently serve on those boards if they no longer are in a position to make decisions?

The Vice-Chair: Half a minute for an answer.

Ms Wright: It's speculation, obviously, about the effect that would have on the ability to recruit board members. I just wanted to also say that our board members are elected from a broad membership representing the community.

Mrs Witmer: A vote?

Ms Wright: A vote.

1710

The Vice-Chair: Mr Kormos.

Mr Kormos: Is there anything more you wanted to say in response to that?

Ms Wright: About the vote?

Mr Kormos: Yes, because he cut you off.

Ms Wright: That's his job, Mr Kormos.

The Vice-Chair: Yes, that is my job.

Mr Kormos: Don't use up my time, Chair.

I'm giving you some of my time now to finish your response.

The Vice-Chair: He's asking the same question.

Mr Kormos: No, that's not what I was doing.

The Vice-Chair: You presented it.

Mr Kormos: Let us do what we've got to do here. We'll move along more quickly.

Ms Wright: Our board members are elected by community members. This year we have approximately 700 members from the community. There is the potential to choose from a slate presented by the nominating committee and other members who are nominated from the community. I just wanted to let you know that.

Mr Kormos: I know a whole lot of hospital board members, and most of the ones I know work incredibly hard. Even the ones I don't agree with work incredibly hard at what they're doing.

Ms Wright: You're right. They do.

Mr Kormos: I acknowledge that, right off the bat.

What about, in a democratic society, democratically elected hospital boards, in the same manner and perhaps at the same time as we elect city councillors, trustees to the board of education etc?

Ms Wright: So I would have to run a campaign?

Mr Kormos: Yes. That's what these folks here—

Mr Kim Craitor (Niagara Falls): Signs?

Mr Kormos: If you're inclined.

Ms Wright: Do you think that's a good idea?

Mr Kormos: I'm asking you. You know what I think. I wouldn't be asking the question if I wasn't an advocate of it. I'm asking you, what's wrong with that? If people do that to be on the board of education, if people do that to become members of the Legislature, if people do that to become members of big-city and small-town councils—the stipend in some small towns is \$3,000 or \$4,000 a year—what about hospital boards?

Ms Wright: I want to know whether the hospital board would still be volunteers. Would this become a paying position, or would it continue to be—

Mr Craitor: It would become a political body.

Ms Wright: It would become a political body?

Mr Kormos: It is now, some would argue.

Ms Wright: I am a volunteer, so I do not get paid for what I do. I think it becomes a different business when you're paid for your work.

The Vice-Chair: Ms Wynne.

Ms Wynne: I'm just going to make a couple of comments, and then Mrs Mitchell has a question.

I just wanted to clarify the section 9 amendment. The wording—and you can get a copy of this on the other table—will be amended to permit payments by public hospitals and mental health facilities for insured services rendered in those facilities; for example, payments to hospitalists, laboratory physicians. That's the language.

Ms Wright: We understand.

Ms Wynne: As far as the incentive recruitment bonuses and locum coverage, the bill will be silent on those. They fall outside the scope of the bill, so there should not be an impact. There would not be an impact on those particular pieces.

Ms Wright: That's good to know.

Ms Wynne: I wanted to make that clear.

Mrs Mitchell has a question.

Mrs Carol Mitchell (Huron-Bruce): I just would like further expansion: You were talking about rural hospitals, and I also was reading your locations. I represent the most rural riding—maybe our definition of "rural" isn't quite the same. But I'm looking for an expansion. Because I come from a rural area, this legislation is so important to me, because it's the continuum of care and community health, and that's what we need in rural communities, when we simply don't have the same access to health care in our communities. So I must say that your comments here—I was quite taken aback. I look for further expansion of rural concerns.

Mr Brian Lemon: Certainly one of the major concerns is the ability to provide adequate incentive for physicians to work in hospitals when there is huge incentive in the fee schedule for them to work in their offices. Stemming the tide of physicians withdrawing from hospitals is a real threat in small communities. The critical mass is not in the hospitals to present them with lots of opportunities to earn money, so in a number of cases they are withdrawing their service.

The second element relates to the funding plan and performance expectations, which certainly are very graphically evidenced by Lakeridge Health. When we became responsible for both small and large hospitals, all the funding credits that came with the small hospitals were discontinued. The performance expectations of us are to manage our four hospital sites as if we were a single hospital operating on a single site. There's no recognition that our smaller sites are more costly to provide the same amount of care, because they lack the critical mass. So that's a real threat in the way government has applied the rules and so forth of this kind of direction.

Mrs Mitchell: I'm going to reinforce: As you knew, this is where we were going to go. Community health care is what works in our rural communities. Thank you very much for reinforcing the direction we're moving in for health care.

The Vice-Chair: Thank you very much for your presentation this afternoon. We appreciate your coming and presenting to us.

At this time, I would like to thank all the stakeholders and the presenters who came to make deputations today.

I'd like to thank the committee members for their patience with me and all those who were associated with the logistics.

We're adjourned to this room at 10 am tomorrow.
The committee adjourned at 1716.

STANDING COMMITTEE ON JUSTICE AND SOCIAL POLICY

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Mrs Carol Mitchell (Huron-Bruce L)

Mrs Elizabeth Witmer (Kitchener-Waterloo PC)

Also taking part / Autres participants et participantes

Mr Peter Kormos (Niagara Centre / -Centre ND)

Mr Rosario Marchese (Trinity-Spadina ND)

Mr Thomas O'Shaughnessy, senior policy analyst, health system policy unit,
Ministry of Health and Long-Term Care

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Legislative Assembly of Ontario

First Session, 38th Parliament

Official Report of Debates (Hansard)

Wednesday 25 February 2004

Standing committee on
justice and social policy

Commitment to the Future
of Medicare Act, 2003

Chair: Kevin Daniel Flynn
Clerk: Susan Sourial

Assemblée législative de l'Ontario

Première session, 38^e législature

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Comité permanent de la
justice et des affaires sociales

Loi de 2003 sur l'engagement
d'assurer l'avenir
de l'assurance-santé

Président : Kevin Daniel Flynn
Greffière : Susan Sourial

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LEGISLATIVE ASSEMBLY OF ONTARIO

**STANDING COMMITTEE ON
JUSTICE AND SOCIAL POLICY**

Wednesday 25 February 2004

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

**COMITÉ PERMANENT DE LA JUSTICE
ET DES AFFAIRES SOCIALES**

Mercredi 25 février 2004

The committee met at 1003 in room 151.

**COMMITMENT TO THE FUTURE
OF MEDICARE ACT, 2003**
**LOI DE 2003 SUR L'ENGAGEMENT
D'ASSURER L'AVENIR
DE L'ASSURANCE-SANTÉ**

Consideration of Bill 8, An Act to establish the Ontario Health Quality Council, to enact new legislation concerning health service accessibility and repeal the Health Care Accessibility Act, to provide for accountability in the health service sector, and to amend the Health Insurance Act / Projet de loi 8, Loi créant le Conseil ontarien de la qualité des services de santé, édictant une nouvelle loi relative à l'accessibilité aux services de santé et abrogeant la Loi sur l'accessibilité aux services de santé, prévoyant l'imputabilité du secteur des services de santé et modifiant la Loi sur l'assurance-santé.

ONTARIO MEDICAL ASSOCIATION

The Chair (Mr Kevin Daniel Flynn): Ladies and gentlemen, if we could call to order, our first delegation of the day is from the Ontario Medical Association. I've got Dr Larry Erlick and Dr Ted Broadway. The time is 10:03. You have 20 minutes to use any way you see fit. At the end of your presentation we will share time among the three parties to ask you questions on a rotational basis. Welcome. The floor is yours.

Dr Larry Erlick: I'm Dr Larry Erlick, president of the Ontario Medical Association. Good morning. I'm here representing Ontario's 24,000 physicians with my colleague Dr Ted Broaday, OMA executive director of health policy, and Mr Jim Simpson, OMA legal counsel.

I would like to start by reminding members of the committee of the problems facing physicians and patients in the province today. Right now in the province of Ontario, there are nearly 118 communities that are considered underserviced and almost one million patients who don't have timely access to a family physician.

In a recent survey of 2,000 doctors in the province, we learned that one in six is considering leaving the province, one in five is planning to retire in the next five years and one in five is considering leaving the profession altogether. Doctors in the province are considering all of

these things because they are concerned about their inability to provide to their patients the quality care they were taught to give and are frustrated at the obstacles they encounter each and every day trying to provide that care. Long waiting lists for treatment and tests are impacting on the ability of physicians to care for their patients.

I know that most of you on this committee must be seeing the direct impact this shortage is having on your communities as well. In the last few weeks, I have travelled to Peterborough, London, Sarnia, Barrie and Chatham. In each community, I have heard from families how this shortage is impacting on their lives, I have heard from businesses how this shortage is hurting their productivity and their competitiveness, and I have heard from local politicians how this shortage is hurting their communities.

We have reached a crossroads in health care today. We need to take immediate steps to improve access to health care for Ontarians. In short, we need to make Ontario an attractive place to practise medicine again. Doing this will allow us to recruit new doctors and to retain those already working hard to care for our families.

Bill 8, if enacted, will do the opposite. Doctors who are considering leaving the province will leave, doctors who are considering retiring will retire and the few doctors who are currently considering moving to Ontario won't come.

This bill has nothing to do with improving accessibility since it ignores the real problems in the system: chronic underfunding and a lack of resources. Issues like queue-jumping, block fees and opting out are symptoms of these chronic problems.

Bill 8 plainly states that the minister would become all-powerful in dictating anything he wished about terms of service, payment, working conditions or anything else he decided to put in a contract, because he can impose contracts on anyone, void previous agreements and take away the parties' right to recourse. The minister, under the bill, has decided to dictate a set of rules to govern and enforce these agreements, to use high and unsupportable fines, and if that fails, to throw hard-working doctors in jail. Bear in mind that this was not for some criminal offence, nor was it for some transgression of care to a patient. And it was not for performing your duties inadequately. No, rather it was for simple administrative matters.

The minister has stated that the bill needs to be amended, and we agree. The minister has announced to the committee some general approaches to the amendments to certain sections. However, these proposals do not go far enough and several important issues are left in the bill.

First let me address the part on accountability. The medical profession supports accountability and our track record on this is abundant and clear. We have been part of the group, along with the Ontario Hospital Association, in developing the accountabilities for physicians practising in hospitals. We were an integral part of the development of the Regulated Health Professions Act, which articulates the accountabilities of professionals to their college. Also, it was the OMA that over three years ago first called for accountability to be included in the Canada Health Act, a recommendation we were happy to see Mr Romanow embrace.

However, as drafted, this section is not about accountability at all but rather is a control mechanism for the minister. Furthermore, any accountability that might devolve from this part goes only one way: to the people who practise and deliver health care. Bill 8 speaks nowhere about the accountability of the Ministry of Health.

Doctors could support an accountability provision which outlined the commitments and obligations of all parties to the delivery of health care, including the ministry, and which had provisions for the regular reporting of progress, mid-course adjustment and corrective action where required.

The patients of Ontario expect us all to be accountable for what we do and they have a right to do so. This legislation should be rewritten to reflect that.

As a general statement, the provisions for penalties and punishments and matters of due process and fairness must all be redressed. This legislation treats all doctors as criminals and does not respect the hard work and dedication physicians show their patients.

Section 16 of Bill 8 deals with what are commonly called block fees. Block fees exist for things doctors must do to provide quality health care but that OHIP will not pay for. As such, they are not an insured service and are regulated and subject to enforcement by the College of Physicians and Surgeons of Ontario.

Ten years ago physicians, under the leadership of the OMA in collaboration with the College of Physicians and Surgeons of Ontario and the government of Ontario, set up guidelines to regulate block fees. The OMA has firmly established guidelines for third-party uninsured services for physicians to follow. Block fees should also not be confused with extra-billing, which has been outlawed in Ontario. We have provided the committee with a detailed package of existing CPSO regulations around block fees, the OMA Physician's Guide to Third-Party and Other Uninsured Services, and a detailed commentary on various sections of the bill.

We are prepared to work with the college of physicians and surgeons to enhance the transparency and access issues related to block fees as part of our commitment to rigorous self-regulation.

1010

Nobody knows and understands the frustration and negative impact wait times have on patient care more than doctors. The minister has proposed a mandatory reporting requirement for those paying to jump the queue, but fails to address the root of the problem, which is the underfunding of the system that results in unacceptable waiting lists in the first place. When you are waiting four months for a loved one to get a test to find out if they have cancer, people become anxious, desperate and look for ways to speed up the test. The government should focus its attention on fixing this problem by providing doctors and hospitals with the necessary resources to reduce wait times for patients. The problem isn't the patients, their families and those treating them; it's the wait lists.

If the government wanted to address queues, it would identify those tests and treatments for which there is presently a long waiting time and would take measures to address the urgent patient needs demonstrated by these long queues. It would enunciate to the public a mechanism and a procedure for addressing these and make promises on how long the waiting time would be for any particular item. That would address the problem of queues and wait lists.

So, as we look at Bill 8, we see a bill which does not do what it is purported to do. It does not address a common vision of shared responsibility; it does not address the queues and waiting lists for patients; it does not have fair and reasonable procedures in it. Physicians' civil rights are waived and they are denied protection under the Statutory Powers Procedure Act and Provincial Offences Act.

The process of dealing with physicians in Bill 8 is very similar to the MRC—medical review committee—process that presently exists. When in opposition, Dalton McGuinty and the Ontario Liberals condemned this unfair process and supported the OMA's call for a moratorium on MRC reviews pending an independent review. Experience has shown us that that kind of environment has unintended consequences. For example, just this past weekend at the Liberal AGM in Windsor I heard from a minister who lost three doctors last week because of the MRC process. This same community was already facing a doctor shortage that is now worse.

What Bill 8 does is change the billing practices of about 40 physicians, impose a draconian solution to the wrong problem, seize regulatory power of an already self-regulated matter and promise to bring chaos to hospitals. We have the minister's commitment to address some of these issues and we are prepared to work with the minister and address all of these issues. We would also work with the minister to address the issues facing Ontario's patients. We have real solutions to the doctor shortage and access. We can work with hospitals and government to address waiting lists for surgery. These should be addressed in any bill on accessibility, and, as a profession, we are committed to work with the government to this end.

We must change Bill 8 so that doctors who are considering leaving the province will stay, doctors who are considering retiring will continue to practise, and the few doctors who are currently considering moving to Ontario will come. Thank you.

The Chair: Thank you, Dr Erlick. You've used about 11 minutes and left us with nine minutes for questions, beginning with the official opposition for three minutes.

Mrs Elizabeth Witmer (Kitchener-Waterloo): Thank you very much, Dr Erlick, for your presentation. I find it rather frightening, because we've now heard from you, the physician community in the province of Ontario; we've heard from the Ontario Hospital Association and its members; and we've heard from the unions such as CUPE and others, and there seems to be widespread concern and anxiety about this bill. Despite the fact that the minister has said he's meeting with all of the groups and he has indicated there are some amendments he may be making, it does not seem to have alleviated that anxiety. I guess I'm particularly concerned about the fact that in surveying your members you have now learned that despite the fact that one million people won't have a doctor if this bill is passed as is, we will lose even more. This bill is not going to improve accessibility as the government claimed it would. It's not going to improve the commitment to medicare.

What changes do you need to see to this bill in order that your members will continue to serve the people in this province and not seek to retire or leave this province? What is it specifically that you must see in this bill?

Dr Erlick: We have to improve access to care and resources. That's how we're going to alleviate the problems facing our patients. We have provided a detailed recommendation on several of the amendments, but the underlying problem is access.

Mrs Witmer: So you don't see this, in any way, shape or form, as improving access to care?

Dr Erlick: No.

Mrs Witmer: What are the sections of the bill that you believe need particular attention? Are there some that should be withdrawn? Are there some that should be totally rewritten?

Dr Erlick: I'll turn to Dr Broaday.

Dr Ted Broaday: The accountability provisions need very vigorous redrafting. The accountability provisions really aren't accountability provisions at all; they're control mechanisms. On the other hand, they could be written such that accountability was really in it and they could also be written in a way that they did address access issues. So I believe that with some major redrafting it would be possible to do a pretty good job right in this portion of the bill.

I also think that if you look at some of the issues that are in part II of the bill, there needs to be some work there, but they're more technical.

Ms Shelley Martel (Nickel Belt): Thank you, the three of you, for being here today. You used some pretty strong language. I see, "This bill has nothing to do with

improving accessibility ... it ignores the real problems in the system," "this section is not about accountability at all, but rather is a control mechanism for the minister," and then, near the end, "What Bill 8 does is change the billing practices of about 40 physicians, impose a draconian solution to the wrong problem, seize regulatory power of an already self-regulated matter and promise to bring chaos to hospitals."

The only thing I think you missed was in section 29, where it says that the minister can require people to hand over information within the meaning of the remedies for the Organized Crime and Other Unlawful Activities Act, which is also a pretty obnoxious section of the bill, which I don't see from the minister's letter he has any intention of taking out of the bill either.

You said to us that you saw what the minister proposed in terms of potential amendments that he released via the parliamentary assistant last week and your opinion doesn't seem to have changed. Am I correct in that assumption?

Dr Erlick: What we're addressing is the bill we have before us. We have not seen the final written amendments, so we can only comment on what we have in our hands to comment on.

Ms Martel: I apologize. We haven't seen final amendments either. What we saw is a kind of draft framework that the minister has put to us, which makes some suggestions regarding changes in some specific areas. The fact is, the minister will still have all the authority to bring forward compliance measures and orders and deal with CEOs, and nothing to deal with section 29 and organized crime.

Dr Erlick: I might only comment that the tone of the original Bill 8 is such that we will not feel comfortable until we see final amendments before we can comment.

Ms Martel: Yes, you want to see the actual wording. We all do.

Tell me, what should be in the bill regarding the accountability of the minister to the health care system and to patients? You've talked about accountability being a one-way street. We've heard that often enough. What has to be in here to show that the minister has some accountability back to the system and patients?

Dr Erlick: You're talking about shared accountability. I'll let Dr Broaday give a better example.

Dr Broaday: Actually, you can look a little bit to the British example, where Mr Blair made a commitment to patients to act on waiting lists and he actually did articulate in the context of each particular problem in the waiting list how he would address it. That says to the public, "I recognize you have a serious health care problem in this area; it's real; I will address this one," and he took them on one at a time, with some success. Quite frankly, that's a banner for everyone to read.

Ms Monique Smith (Nipissing): Dr Erlick, I'm just interested, as Ms Martel outlined, in some of the hyperbole in your address this morning. It is a bit rough. Have you not been in discussions with the ministry staff and

the minister for a number of weeks now on the possible amendments?

Dr Erlick: We have been in discussion on some of the amendments, yes.

Ms Smith: Yes, and you're aware of the proposed amendments, the general areas—we've discussed a number of areas in which you have concern, is that not true?

Dr Erlick: There are significant areas in the bill on which we do not have any agreement on changes.

1020

Ms Smith: But you're clear that the accountability agreements referred to in this legislation, when the proposed amendments will be put forward, do not apply to doctors or to physicians' group practices.

Dr Erlick: We have requested, obviously, those—

Ms Smith: Is that your understanding of the intended amendments, Dr Erlick?

Dr Erlick: Our understanding of the intended amendments?

Ms Smith: Yes. Is that your understanding of the intended amendments?

Dr Erlick: That physicians and group practices will be excluded? I'm not sure how integrated health care networks and other things will be affected. We do know IHFs and hospitals will be affected. Executive administrators within hospitals may be affected, which would be a problem with physicians taking on jobs as executive administrators within hospitals.

Ms Smith: That's a lot of "mays." I wanted to talk to you specifically about your comments about block fees, that, "The OMA has firmly established guidelines for third-party uninsured services for physicians to follow." How are patients able to access the list of block fees from their physicians?

Dr Erlick: First of all, block fees are strictly regulated by the College of Physicians and Surgeons. We support any physician who violates those guidelines being punished. Block fees are also an option. No patient in this province has to pay a block fee. They cannot be denied health care; any physician must provide the care, whether or not they choose to pay block fees or pay for uninsured services as they are provided.

Ms Smith: We've had three different depositions at this hearing from different parties who have outlined that when they've requested a list of fees from their physicians, they've not been available to them and they've been told to go to the OMA. When they've asked at the OMA, they've been told that there's a charge of \$100 for that document. Is that your understanding?

Dr Broadway: No, that's not true. If you ask for the fee schedule, there is a charge for it, but that's not for the block fees. That's a fee schedule of everything. That's for the cost of appendectomies, the cost of—well, the fee schedule.

Ms Smith: So if a patient were to call the OMA asking for a fee schedule, they'd be told that there's a charge for that?

Dr Erlick: In fact, we have provided the committee with the third-party billing guideline that the OMA

recommends to its members. My understanding of the block fee regulation is that the physician is to provide the patient with the two options: to pay a block fee for certain services, or otherwise a catalogue of services that the block fee includes.

Ms Smith: And the OMA recommendations are just such: recommendations, right? Doctors are not regulated as to what they can charge for those specific—

Dr Erlick: We are a self-regulated profession by the College of Physicians and Surgeons of Ontario. The guidelines for block fees are strictly enforced. There have been cases, which we could provide you with as well, of physicians who violated those guidelines and have been subject to—

Ms Smith: And there are third-party organizations—

The Chair: Thank you, Dr Erlick.

Ms Smith, your time has expired.

Thank you very much for attending today. Your presence and input were certainly appreciated.

PAUL MacDONALD

The Chair: Our next delegation is Mr Paul MacDonald, or perhaps it's Dr Paul MacDonald. Same rules as everybody else, sir. You've got 20 minutes. At the expiry of the presentation you make, if there is any time left over, we'll split that time proportionately among the three parties on a rotational basis. If you would introduce yourself for Hansard, the floor is yours. It's 10:24.

Mr Paul MacDonald: Thank you, Chair, ladies and gentlemen of the committee, for giving me this opportunity to discuss issues in regard to this proposed bill.

Hello. My name is Paul MacDonald, and I'm here on behalf of my unionized co-workers at a downtown Toronto rehab centre. As a registered practical nurse, I work on a daily basis providing direct care to my clients, who, through no fault of their own, cannot provide this necessary personal care.

Let me begin by stating that no company or corporation should profit from the illnesses of the citizenry of this province. For an individual company and its shareholders to make money on the backs of the disabled and acutely ill is obscene, to say the least. The public system that we are fortunate enough to have is what separates us from those to the south. As an employee of a downtown Toronto rehab centre, I have to say that employees, both unionized and non-unionized, have been fortunate enough over the past few years with our cutbacks and reorganization. People were displaced, shuffled and reclassified; however, no one lost their job.

However, we have not been immune from creeping privatization. Laundry and linen have been farmed out. Just recently we lost our hairdressing staff. As a result, this has put some stress on our complex continuing-care residents at another site, who now have to wait longer and pay more for hairdressing services.

Positions in our housekeeping department have not always been filled, for different reasons, mainly budget-

ary. This has created more work and stress for those left to pick up the slack. Our patient care units, as a result, are not as clean as they used to be.

I, with my coworkers at the rehab centre where I am employed, do not want to see these positions and others eroded further by a profit-generating private company. Staff in these and other departments would be further reduced to make a profit for the company. Fewer bodies on the payroll equates to a higher bottom line for company X but a reduced quality of services for Ontarians.

As front-line caregivers during SARS, references were made to us as the heroes of health care. This was only a few short months ago. Now, here I am, defending free collective bargaining and the spirit of universality. Does this make sense?

Passing such a heavy-handed, undemocratic, autocratic piece of legislation is beyond Canadian comprehension. To give the health minister such broad, sweeping powers under the guise of an accountability agreement or to issue compliance directives is not democratic.

Section 30 of the bill seeks to insulate the crown and minister from any legal liability resulting from any actions taken in connection with accountability agreements or compliance directives. Anyone who fails to comply will be fined \$100,000. Thus my salary and benefits could be rolled back. In this bill, as it stands, we will have no choice. There will be—is—no dialogue. Take it or take it. My many unionized public sector compatriots and I have a problem with this dictatorial manner that is potentially being forced down our throats.

These provisions have been drafted in extremely broad and general terms. They grant the minister virtually unprecedented power to require individuals and organizations to comply with ministerial health care initiatives. Potentially, these steps could override collective agreements and other negotiated agreements.

As was the case in BC with the new Liberal government in place and a deficit of \$2.5 billion, the government under Premier Campbell tabled a similar bill. Overnight, Bill 29 caused the layoff of several thousand health care workers in that province—several thousand who paid their taxes, had mortgages to pay and kids to be put into post-secondary. Thousands of lives were disrupted—lives of health care employees who believed in a system. It was the same system that we, the health care employees of this province, have: a public system.

Bill 8 as it stands requires revision. As previously said, the areas are part III, sections 19 to 23.

In closing, I and my many brothers and sisters in the health care sector would like reassurances to our concerns. As with many campaign promises that were not met by the current Liberal government under Dalton McGuinty, promises that were completely changed—for example, P3 hospitals and private MRIs and CT scans—we who work for a fair wage, with livelihoods that were determined under negotiation over these many years, would like the health minister to amend the flawed sections in this bill that the people and organizations of

this province have brought to the attention of this government.

Since many promises and plans pertaining to health care have been broken, we, the stakeholders in health care in this province, not big-name multinational corporations with questionable labour practices like Sodexho, Aramark, Compass and Drake, wish for the health minister to declare in writing that the amendments have been made, not just for current collective agreements but for all future collective agreements. Thank you.

1030

The Chair: Thank you, Mr MacDonald. You've used up about eight minutes, leaving us with 12. So in between three and four minutes each, starting with Ms Martel.

Ms Martel: Thank you, Mr MacDonald, for taking time to come today. Let me say that the minister has told this committee that the bill will not impact on collective agreements, that trade unions will not be considered health care providers. We wait to see the amendments, because we don't have that yet. What was interesting, however, is that in the proposals the minister gave to the committee last week, there does not appear to be a change in the compliance directives that the minister has. Let me get to that in a roundabout way. You told the committee already that laundry and linen staff at your organization have been essentially contracted out; am I correct?

Mr MacDonald: That's right.

Ms Martel: And I'm going to assume that CUPE staff were affected. Were they unionized staff?

Mr MacDonald: They were, but they were reassigned to other departments or positions.

Ms Martel: In terms of that redeployment, did people's wages and salaries stay the same, or would you know that?

Mr MacDonald: I believe they would.

Ms Martel: They did or you're not—

Mr MacDonald: I'm not 100% entirely sure.

Ms Martel: Here's what I'm worried about. Under the compliance directives, the minister's powers are pretty broad. I can see that the minister could say to an institution—a hospital, a long-term-care facility, for example—"In order to make savings, we think you should contract out your housekeeping, your laundry." If successor rights don't apply, then a number of people could lose their jobs. You were lucky in your case because the organization was able to give people other jobs. I'm not sure that's going to happen everywhere else. So my concern is that while trade unions might not be considered health care providers and so they won't be part of the bill in that way, under the section on compliance directives, people and their positions could still be affected if the minister, for example, argues that services should be contracted out. Do you have any comments about that section at all?

Mr MacDonald: All I have to say, as with the previous gentleman, the physician, is that we're just waiting to see the final amendments. There were remarks by Mr Smitherman dated February 16, 2004, to the standing

committee. He's on record saying, "Then there's CUPE. Bill 8 can't open collective agreements, and unions have never been subject to accountability agreements, but we've agreed to make that more explicit." We're just waiting to see the final amendments.

Ms Martel: You want to know for sure what that says.

Mr MacDonald: Yes.

Ms Martel: I had one other question in terms of the sweeping powers of the minister. He may make changes that will not affect collective bargaining. There are still other provisions in the bill that you noted that provide him with some really broad, sweeping powers. Do you think it's appropriate for a minister to have those kinds of broad, sweeping powers essentially to take over boards of a hospital or to take over a management board at a long-term-care facility?

Mr MacDonald: No. That's why we have hospital boards and that's why we have unions in place to negotiate contracts, and there are dispute mechanisms in place if we can't come to an agreement.

Ms Kathleen O. Wynne (Don Valley West): I have a question and then I think Mr Duguid is going to make a comment.

Thanks for coming today, Paul. You have a copy of the proposed amendments and, you're right, the language of the amendments is not finalized yet because we're still in the process of committee hearings. Do you have a copy of the proposed amendments?

Mr MacDonald: Yes. I gave them to—

Ms Wynne: Yes, you gave us some amendments from Sack Goldblatt Mitchell. This was part of your presentation. But we have a letter from Mr Smitherman that has some language around proposed amendments, so we'll make sure that you get a copy of that just so you know the direction we're going, which is to confirm what Mr Smitherman said in his speech on the 16th around the accountability agreements not being between unions and the minister but being between the minister and hospital boards or the minister and organizations. So it's not between individuals and it has nothing to do with reaching into collective agreements.

I wanted to ask a question too. This bill is about making sure the dollars that go into public health care are spent where they should be spent. As a nurse, my guess is that there are some things that are going on in the health care system that you're not too happy about, that don't have anything to do with Bill 8, but have to do with practices and the status of nurses and the hiring of the nurses. Is that a fair statement? The number of full-time nurses, the number of contracted—

Mr MacDonald: Yes. Under the SARS situation that was apparent. That would be part of it.

Ms Wynne: OK. So I just want to draw your attention to the speech that Mr Smitherman made yesterday, and I think Mr Duguid may follow up on this. What he said was that he is going to put \$385 million into the hospital sector to deal with current deficits, but "\$50 million of that \$385 million," he says, "will be targeted exclusively

to create full-time nursing positions and improve the safety and working conditions for nurses. If hospitals fail to reach targets for creating full-time nursing positions, they will lose the funding." So there will be a consequence. In other words, what we're trying to do is target the money at the areas that we know and that we've been told by nursing associations—that's just one example—are real problems. What do you think about that strategy to address your issues?

Mr MacDonald: Not just nursing, but there are other departments that are critical to the running of a hospital and maintaining top-quality services. I did mention them in my report.

Ms Wynne: Sure, but I guess I just wanted you, as a nurse, to understand that those are the kinds of accountability mechanisms we're trying to put in place. We're trying to say, "This is an area that is in serious trouble." The health council would identify that and we're trying to tag the money to that.

Mr MacDonald: I agree, as long as the spirit of free collective bargaining isn't removed.

Mr Brad Duguid (Scarborough Centre): We've received a number of letters from front-line workers, a number of form letters as well, some of which are suggesting that somehow the minister would be allowed to strip their job security provisions from their collective agreement and roll back their wages and benefits. We're talking about a working sector that has been under incredible stress. There's still burnout out there from the SARS thing and we've seen it over the last couple of years. My sister is a nurse at North York. She was in the middle of the SARS crisis and she's told me about the burnout and stress that goes on there. I served on the board of Scarborough Hospital and I've seen that first hand as well.

It concerns me when there's misinformation out there that's going to a group of people who are already at the breaking point now in terms of stress. Given that misinformation has gone out and the president of your union was advised as of January 13 that labour unions were not going to be subject to accountability agreements, would you undertake to share with your colleagues that this is in fact what is going on right now? I know you don't have the direct amendments. You're going to get them; they'll be coming forward, I believe, probably in March.

Ms Wynne: March 9.

Mr Duguid: Even before then, would you please undertake to share with your colleagues that this is the direction we're heading in to try to reduce that stress level somewhat?

Mr MacDonald: That's fine, as long as the amendments are in writing and we can see the amendments before the bill is passed, because that's the concern we have.

Mr Duguid: Well, let them know the amendments are going to be coming in writing, but let them know what we've said as well so that they have all the information. Because as far as I know, Mr Ryan has yet to inform the membership of the direction that's taking place here and

the commitments the minister has made to him personally as of January 13, in a meeting they had. I think that's unfortunate, because this is a group of people who are working very hard in a very stressful environment.

Mrs Witmer: Thank you very much, Mr MacDonald, for coming. I really appreciate that you did take the time to come. Obviously this bill is causing a great deal of anxiety for yourself and for your colleagues. Some of the statements you've made certainly indicate this bill is flawed, it's heavy-handed, it's undemocratic, it's autocratic, it's dictatorial, it gives unprecedented power to the minister. Are these concerns and fears that you have really quite widespread within the organization where you work?

1040

Mr MacDonald: It is. All we have to do is look back at what happened in British Columbia after Bill 29 was passed: 6,000 unionized employees lost their jobs once the privateers came in; or if they were kept, they were kept at substantially lower wages with a gutted benefits package. The same seems to be happening in Quebec right now. With the prospect of the P3s, this bill seems to go hand in hand; especially the sections that I mentioned. A private corporation can't make a profit if CUPE employees move over to the new hospital with their collective agreements and contracting-out language.

Mrs Witmer: If you take a look at some of the comments that were made by the minister in his speech yesterday about funding for hospitals and the fact that they can't expect this funding in future years, obviously somebody's going to be looking at places where they can achieve some savings. So I think some of the points that Ms Martel has made and some of the concerns you have are really reason for concern. In fact, we've heard a lot about the fact that this legislation seems to base itself in some respects on the BC model, and so I think your concerns are quite legitimate.

I would ask the Chair, in light of the fact that this bill is causing such anxiety, are we going to receive the amendments from the minister long before we're going to have to debate them?

The Chair: I can investigate that. As I understand, we'll be starting our clause-by-clause on March 9. I will certainly undertake to find that out.

Mrs Witmer: I think it's really important that the stakeholders, who do have very legitimate concerns, have an opportunity to see these amendments and then have an opportunity to respond, because despite the fact that assurances have been given that some changes will be made, it appears to me that whether it's unions, doctors or hospitals, people are not feeling very reassured that this bill is going to change significantly to respond to their concerns.

The Chair: Just to be clear, the subcommittee has established March 8 at 5 o'clock as a deadline for amendments. That should be viewed, in my opinion, as a minimum as opposed to a maximum. I will check into it.

Mrs Witmer: Which would mean people would only have overnight, from 5 o'clock to 10 o'clock the next day.

The Chair: That's why I'm saying that would be a minimum deadline.

Mrs Witmer: That would be a pretty short timeline when we've heard such significant concerns from stakeholders.

The Chair: You've got about 30 seconds, Mr Arnott.

Mr Ted Arnott (Waterloo-Wellington): Thank you, Mr MacDonald, for your presentation today. Thank you for coming and offering us your views. Yesterday, the minister gave a speech, and this is the one where he encourages the deputy minister to ask health stakeholders to buy a table to attend at \$650 a shot. Apparently afterwards, in an interview with the *Globe and Mail*, the minister said, "We're going to be pretty bloody-minded and determined about achieving results." How would the front-line health care workers that you represent respond to such an inflammatory statement?

Mr MacDonald: With concern.

The Chair: Thank you, Mr MacDonald, for coming today. We appreciate it.

ONTARIO ASSOCIATION OF SOCIAL WORKERS

The Chair: Our next delegation comes to us today from the Ontario Association of Social Workers—Drummond White and Gillian McCloskey—if you would come forward and make yourself comfortable. Thank you for coming today. Same rules as everybody else we're hearing from in Toronto: You have 20 minutes; you can use that any way you see fit. At the end of the presentation we'll apportion the remaining time amongst the three parties for any questions or concerns that need to be addressed during that period. I've got 10:46 and you've got 20 minutes.

Mr Drummond White: Thank you very much, Mr Chair. Good morning, ladies and gentlemen. My name is Drummond White and I'm the vice-president of the association of social workers. With me is Gillian McCloskey.

Ms Gillian McCloskey: I would like to introduce our association, although you have seen and heard presentations from three of our branches, the first being in Sudbury, then in Ottawa and also in Windsor. On Friday, one of our branches will be presenting in Niagara Falls. So you probably have a good sense of what our association is about, the fact that we have over 3,200 members who have social work degrees at the doctoral, master's and bachelor's level and that we are a member of the Canadian Association of Social Workers. That, in turn, belongs to the 76-nation International Federation of Social Workers, so we're all interconnected.

The other point that we would like to make as an introduction is that a major employer—perhaps the major employer—of social workers are hospitals and community-based health services. Increasingly, social workers are in private practice and serve in that capacity in a counselling role. Also, the major providers of psychotherapeutic counselling are social workers. Historically,

social workers have been advocates of the disadvantaged and vulnerable populations. The beliefs, principles and values behind that are that that would make a significant contribution to the health and well-being of society as a whole, that that really enhances and enriches the total community.

Mr White: What we were excited about as an association and as a profession was that the government was undertaking this new bill and there was an intent to put forth a commitment to the future of medicare. Of course, we've had a lot of discussion in the last number of years about where medicare should be going and the kinds of reforms that are necessary. This bill was introduced last fall. It creates some new mechanisms, but we have a concern that, as it stands, the bill may not further the implementation of the principles of the Canada Health Act nor provide adequate democracy, transparency or accountability. Additionally, it may not prohibit the further erosion of the scope of medicare and the increasing problems of privatization, profit-taking and two-tiering of those services that have been delisted.

Failing to address some of the critical issues relative to preserving and reforming medicare and moving its values into the 21st century might create a very serious missed opportunity for leadership at this crucial time. This brief will highlight some of our key values that are consonant with and expressed through the comprehensive set of standards, goals and values that inform medicare as we know it and indeed as is set out already in the preamble of the bill. And we will address one significant issue in the future of medicare, the enactment of primary health care.

We understand that presentations have been made by colleagues to this committee in other parts of the province. Those presentations set out a vision and called for changes in the bill that would ensure a commitment of the Ontario government to the following: rebuilding the universality, comprehensiveness, and accessibility of medicare; prohibiting two-tier medicine and extra-billing; creating a health quality council to report on compliance with the principles of the CHA; prohibiting block fees and charges that create a barrier to access; ensuring public accountability, democratic control and transparency; and putting an end to privatization and ensuring democratic and public, non-profit delivery of service.

I won't go into great detail into those issues because I think they have been made succinctly by my colleagues in Sudbury, Ottawa and Windsor. The issues are fairly clear. As social workers we're often working in the community, although as my colleague mentioned, more social workers are employed in health care centres than elsewhere.

But a lot of the community work is with community agencies: private counselling work, EAPs, a range of health care-related services. So there's a great sense that, as social workers, we are aware of the need for primary health care reform when there are literally hundreds of people in every region of the province on waiting lists for psychiatric or psychotherapeutic services through otherwise public agencies.

The issue about block fees and extra-billing is fairly self-evident. I want to focus primarily, as you'll see in the document at the beginning of page 5, on issues around primary health care reform.

Consumers want to be able to access health care services across the continuum of health and wellness, from preventative to curative to maintenance, in the least intrusive manner possible and in their most natural environment. We envisage that health care services will be most successful and accessible if based in the community, offered by a range of professionals and designed to work with natural support systems such as extended family and friends. Admissions to institutionally based care, either acute or long-term, should be the last resort. We recognize, however, that in some instances, hospitalization or institutionalization is the least intrusive intervention because of the complexity of needs. But in the vast majority of situations, it is the most intrusive and seems to be the bulwark by which everything else is compared.

We must work towards the enhancement and expansion of Canada Health Act principles and, at the same time, address the question of long-term financial sustainability of the health care system. A two-tier system of for-profit and not-for-profit health services existing simultaneously would create a financially unsustainable system. Primary health care reform can be both affordable and relatively predictable in costs, but it's unlikely to get off the ground if it is in competition with private for-profit services.

Ontario wants and needs a comprehensive, interdisciplinary, and universally accessible system of primary health care. Such a system must be delivered by not-for-profit organizations and be publicly accountable. It should be governed, in part, by community involvement in decision-making.

With primary health care reforms, it is imperative that there is an immediate ban on public-private partnerships and new health care services that are offered on a for-profit basis. It is a fact that P3s and for-profit initiatives can incur high costs, the burden of which is on the taxpayers in the long-term. We know that such services eventually create barriers to universal accessibility. Thus, Ontario's health care system must remain publicly funded.

The World Health Organization has long advocated for primary health care reform. The commission chaired by Roy Romanow also called for primary health care reform. Canadians and Ontarians have all expressed a need to press onwards with primary health care reform. These essential reforms can only happen within the context of a publicly funded infrastructure.

As an essential part of the revitalization of medicare, we would like to see primary health care reform anticipated by the present bill. A comprehensive commitment may be forthcoming and the costs have, of course, to be considered. On the other hand, a clear commitment to publicly accountable but not-for-profit health care would be a welcome prerequisite. For these reasons, we

are concerned that the present bill should lay the framework and the groundwork for the future of medicare, including primary health care reform.

We cannot emphasize enough the importance of continuity of care. This includes essential health care sectors that are out of hospital, based in the community, and not specifically covered by the original CHA, such as home care, long-term care and pharmacare. OASW recommends that these essential sectors be included through legislative amendments under the medicare umbrella and under the auspices of a public authority.

In conclusion, the Ontario Association of Social Workers applauds the intent of the bill and would like to see it propelled into the next phase of medicare reform. However, we are concerned that the commitment to medicare that is reflected in this bill may be somewhat tepid. Therefore, we urge that the government fully support a system of health care in Ontario that is comprehensive, multidisciplinary, publicly funded and fully accessible. Furthermore, it should be economically viable and, at the same time, exude the values associated with social justice.

The Chair: Thank you, Mr White. I understand you are the former chair of a standing committee in this building yourself, so welcome back.

Mr White: Yes, thank you.

The Chair: You've left about three minutes for each party. We're going to start this questioning with Ms Smith.

Ms Smith: I'm sorry I missed a portion of your presentation, but I did want to comment on the fact that we have had a number of presentations from the social workers and we really appreciate your team coming out and speaking to us. It's particularly helpful to have a different perspective in these hearings.

As you know, we brought this bill forward after first reading with the full intention that there would be amendments and changes. The minister made that clear from the beginning. We're very pleased at the number of presenters we've had and the amount of input we've had. So we appreciate your coming out and providing us with your review.

Certainly a number of the things that you feel we should be doing in this legislation we are doing. We're looking at ensuring that we have publicly funded, publicly accessible health care and putting an end to two-tier health care.

In your brief you have a bit of a synopsis on the health quality council and I just wondered if you had any input there on membership for the council.

Mr White: I think that the issue there is a very broad one and I wouldn't want to risk putting forth something off the cuff. However, I do think it's so important an area that the issues of transparency and representation need to be in the forefront. I know it would be very difficult to secure an elected body, but certainly we'd like to see a body that represents a broad, multidisciplinary representation of health care services but also, of course, an equal representation from the public, from patient advocates

and patients. Obviously, with an electoral system people would tend to put themselves forward in reasonable numbers.

It's hard to ensure the level of accountability that would be necessary, but there's also a sense that it should be a body that speaks to the province and not to the government or the minister alone.

Ms Smith: You spoke about accessibility and a fear about private hospitals. We are opposed to private hospitals, just so we're clear on that. We believe that all hospitals should be publicly funded, publicly governed. So we appreciate your comments on that.

I also noted that you spoke a little bit about the continuity of care. In my other life these days, I'm doing a review of long-term-care facilities across the province, so I'm hearing a lot about continuity of care and at-home care and institutionally based care. So I appreciate your comments on that and certainly will take those to heart as we continue on.

I also just wanted to comment that in my review of long-term-care—it's kind of unrelated, but you'll forgive me, Mr Arnott, for a minute. One of the things we've noted is that the presence of social workers in the long-term-care facilities is a definite value-add. So I did want to comment on the good work that you're doing there.

Mr White: Thank you.

Mr Arnott: Good to see you, Drummond.

Mr White: Thank you, Ted.

Mr Arnott: I recall vividly your passionate speeches in the Legislature in support of public health care, and certainly what you've said today is very consistent with your public record when you were here as a member of the Legislature.

This is my first day subbing in on this committee and I've been following the debate through the newspapers and some other discussions that have been taking place. It seems to me that we have existing mechanisms to ensure accountability for the money spent for health care. Why do you think that those existing mechanisms aren't working as well as they should?

Mr White: We do have a number of existing mechanisms within professional services, obviously. Most professions within the health care field are governed by professional bodies. Social work is unique in the sense that here in Ontario we're governed under the Ministry of Community and Social Services, unlike other provinces. In other provinces, as well, there's been a shift to the Ministry of Health for the regulation of social work. As I mentioned, that is the primary employer.

That's one area that's very important, but the regulation of hospital-based services through hospital boards is not always seen by the public to reflect the local public's concerns. I know there have been many attempts in the past to look at some way of democratizing that, but that hasn't happened. Of course, for that to occur, it would be through an act of government.

1100

Ms Martel: Thank you for being here this morning, Drummond. It's good to see you. I want to say something

about P3s, because you heard the parliamentary assistant say that of course they're opposed to private hospitals. She didn't say anything about supporting hospitals that are publicly financed, because the hospital in Brampton and the hospital in Ottawa are going to be privately financed, which is a break in tradition in Ontario's history of how we fund hospitals through capital grants.

The prospect in Brampton and Ottawa is that a private consortium will privately build the hospital. That hospital will become a mortgage responsibility and, through its operating budget, which is also a first, will have to pay the mortgage payments. The public of Ontario is going to get dinged in two ways: first of all, we're going to pay more, because it costs more for the private sector to finance capital projects than it does for the government, and second, the private sector isn't going to do this as a charity case. Of course they want a profit. We can expect to pay 15%, 20% more for this construction because it will be built by the private sector, not by the public. Do you think that's a good use of taxpayers' dollars, to actually support private construction, private profit, instead of the government building this through public financing so we ensure that money that should go to patient services does, instead of to profits?

Mr White: It's my understanding that government can borrow at significantly lower rates than private industry can. It usually has a secure level of assets that can be used to borrow against. In consequence, the cost of public construction should be significantly less than private construction. Obviously, as well, there would be a need for the private consortium to make a profit above and beyond their borrowing costs.

I'm not quite sure how it is that a P3 endeavour can make financial sense. I know that in the Ottawa area the eastern branch was very concerned about the P3 initiative there and, I understand, has presented to the committee in regard to that.

On a personal level, I'm not quite sure that it makes a great deal of sense. We have seen P3 endeavours in other areas. There was a highway to the north of Toronto, for example, that started off as a P3 and now somehow it's gone some other way. It seems to be somewhat out of control and offers a somewhat basic service that's no longer accessible to all of the residents of this area. So I think there are a lot of danger points and concerns, but not having studied these things in great detail, I just have to be a humble social worker and question how it is that you could be saving money by spending more.

The Chair: Thank you for appearing before us today. Your input was certainly appreciated.

HALIBURTON HIGHLANDS HEALTH SERVICES

The Chair: Our next delegation is from Haliburton Highlands Health Services, Mr Keith Sansford and Mr Jack Brezina.

Mr Keith Sansford: I'm here by myself today. My board chair offers his apologies. He's about to become a

customer of our service. When I attempted to pick him up this morning at 7 o'clock, he just couldn't make it to the bell. So he offers his apologies.

The Chair: Give him our best wishes. You have 20 minutes. You can use that any way you like. At the end of your presentation, we will use the remaining time split up amongst the three parties to ask you any questions.

Mr Sansford: I have Jack's notes. He had intended to be the presenter this morning. I'm going to try to incorporate his comments into my formalized presentation, so it may get a little disjointed. I apologize at the beginning for that.

Like you, Haliburton Highlands Health Services is committed to accountability and to the preservation of a universal public health care system in Ontario. To this end, we have reviewed Bill 8, the Commitment to the Future of Medicare Act, and believe that it is flawed. As written, portions of Bill 8 could significantly undermine the government's intent to protect medicare in Ontario.

We support the intent of part I of Bill 8, which establishes the Ontario Health Quality Council. We believe the Ontario Health Quality Council should not only report on the state of the health system in Ontario to the public and to the minister but should be empowered to make recommendations to the minister. We also believe that to promote enhanced public accountability, the council should report directly to the Legislature. Bill 8 as currently drafted prohibits board members and senior staff members of a health system organization from being members of the council. We suggest that the perspectives of the hospital sector will be critical to the council, and serious consideration should be given to formalizing a role for the hospital sector on the council.

Provisions in the accessibility portion of the act may potentially prohibit payments to hospitalists, laboratory physicians and other types of doctors to whom hospitals make direct payments. At a time when many hospitals are facing severe physician shortages, we are very apprehensive regarding legislation that would make physician recruitment even more difficult. The accessibility portion of Bill 8 paradoxically may have the effect of reducing access to health care services.

We are gravely concerned with respect to the provisions in part III of the bill, entitled "Accountability." We strongly believe that the bill fundamentally undermines the role of independent local voluntary boards in two significant ways. First, it usurps the role of the board in representing their local community needs by imposing non-negotiated accountability agreements with the hospital. Second, by establishing mechanisms to have hospital CEOs and other senior executives report both to the minister and the board, Bill 8 interferes with a fundamental principle of corporate governance.

We certainly support the notion of accountability, and to this end we respectfully suggest that the bill be amended to provide for a fair, transparent and freely negotiated accountability agreement process between hospital boards and the ministry. Further, the bill focuses exclusively on how to make health care providers accountable

to the government, yet is silent on the government's responsibilities with respect to ensuring the provision of health care. The bill should be amended to clearly state how both hospitals and government would be accountable to achieve the key principles necessary to a universal, publicly funded health care system.

We also suggest that the Public Hospitals Act provides significant measures for accountability of hospitals, such as provisions for the appointment of supervisors and investigators, the ability of the minister to impose terms and conditions on grants and to reduce or terminate grants, loans or any financial assistance. Further, under the Public Hospitals Act, subsection 9.1(1), in making a decision in the public interest, the minister may consider any matter he regards as relevant, including the quality of the management and administration of the hospital, as well as the accessibility to health services in the community where a hospital is located. Bill 8 removes the requirement of the minister acting in the public interest and therefore makes the minister less accountable to the public.

Local community board members and other volunteers provide thousands of hours of their time in order to benefit patient care and services. As well, hospitals depend on our communities for millions of dollars in contributions for patient care and diagnostic equipment, as well as for the local share of new or renovated hospital facilities. We are very concerned that the accountability provisions in Bill 8 will convert hospitals from charitable corporations governed by voluntary boards to government agencies and as a result will irreparably damage future volunteer recruitment and funding support. In fact, it is likely that passage of Bill 8 will result in the cancellation of substantial existing campaign pledges upon which hospitals are depending to finance current capital projects.

With respect to hospital accountability and the expectation that hospitals can control service volumes and costs, we must note a larger health care system issue, namely, that physicians are still the gatekeepers to hospital admissions, diagnostic tests and treatments etc. Payment for physician services provided in hospitals should be made congruent with hospital funding. The assumption that, under accountability agreements, hospital CEOs will ensure tight control of service volumes and related costs is incorrect and will be destructive to the relationships among hospitals and physicians.

1110

We fear that there will not be enough certainty in the bill about what results the accountability agreements are meant to achieve. As the British Columbia Auditor General noted in his 2003 report, if the government intends to hold a hospital accountable for meeting specified performance goals, objectives and standards, the accountability agreement and the legislation must make it very clear who makes the decisions, when decisions are to be jointly made, and how very sensitive or controversial decisions ought to be made.

The more control the government has over hospitals and their CEOs, the more the spectre of political—

partisan—interference is likely to arise in the day-to-day operations of a hospital. We believe that with the introduction of accountability agreements, the hospital stakeholders are likely to perceive that the minister and local MPPS have greater accountability and control over the operations of the hospital. As a result, the stakeholders are more likely to seek the help of their local MPP and the minister in influencing decisions relating to the governance and management of the hospital. Contrary to the minister's intention of making health care organizations more accountable to their communities, we believe the more likely outcome is that the organized stakeholders in the communities, rather than the members of the community, will be able to exert greater influence on the hospital's operations.

In addition, further accountability to the community is lost because the minister will be able to issue compliance directives without considering the public interest or getting an order in council. What measures will be put in the bill to ensure that the minister acts in good faith and in the public interest when the minister issues compliance directives? This is a concern which we believe the British Columbia Auditor highlighted with his suggestion that performance agreements should provide for independent evaluations of health authority performance: "Experience in other jurisdictions suggests that there is a need for independent evaluation and audit, especially when incentives and consequences are involved."

Further, why is the minister fixated on issuing directives to the CEO? The hospital can be made to comply with the minister's requirements via directives to the board, leaving the CEO free of dual accountability.

Will Bill 8 turn hospitals into agencies of the government? The 2003 annual report of Ontario's Provincial Auditor outlines when an organization becomes a government reporting entity. When it does become a government reporting entity, the organization's bottom line is reflected in the province's own financial statements. Currently, the SUCH sector—school boards, universities, colleges and hospitals—is not considered a government reporting entity. There are several criteria that indicate when an organization becomes a government reporting entity, based largely on the power and control that the government holds over the organization's assets and decision makers. Bill 8 may tip the scales and result in hospitals becoming government reporting entities, a result that the government itself is likely not eager to entertain. As a government reporting entity, a hospital would be subject to restrictive Management Board policies and guidelines.

Another area of concern, also identified by the BC Auditor General's report, is whether the ministry has, or can recruit and attract, the kind of personnel who will be able to help the ministry carry out its more hands-on role under Bill 8. For accountability agreements to be effective, the ministry must be able to analyze and react to the issues that arise from the agreements. Bill 8 will create a great deal of potential new work at the ministry level. Does the ministry have this capacity? Can it afford

to retain this capacity? Does it want to expand the health care bureaucracy or downsize it? Will the bureaucratic costs outweigh any related benefits?

We have been encouraged by the minister's stated commitments to continue the ongoing partnership with hospitals and voluntary hospital governance. We share your commitment and are pleased to respectfully submit the above comments on Bill 8.

If I have a few minutes, I'd just like to add some personal comments from the former chair, who would have been able to make them himself had he been here. He refers to the Haliburton Highlands as a rural part of the province, tucked neatly below Algonquin Park. This is Canadian Shield country, with hundreds of lakes that today attract thousands of cottagers and tourists.

Prior to the influx of cottagers, the area relied on the economic return of lumbering and some marginal farming. The isolation of the area created a sense of self-reliance often found in frontier environments. The communities built and maintained their own health care facilities. The Red Cross Outpost Hospital in Wilberforce and the hospitals in Minden and Haliburton were examples of Haliburton county communities rallying to the support of their health care needs.

The facilities in Minden and Haliburton were under the management of the Canadian Red Cross until the 1980s, when they chose to withdraw from the business of operating hospitals. St Joseph's Hospital in Peterborough then took the facilities under their control. While the communities were appreciative of the efforts of first the Red Cross and then the Sisters of St Joseph in Peterborough, there was always an underlying desire in the community to bring the management of the two hospitals home.

A district health council report prepared in the early 1990s under the chairmanship of Jack Brezina reflected that sentiment. It recommended that the Minden and Haliburton hospitals be managed under a joint, locally elected hospital board. The report recognized the limited health care resources in the area and also recommended that the board take on more traditional hospital responsibilities and that it work toward an integrated system of health care that would serve the broad needs of our community.

So in 1997 the Haliburton Highlands Health Services Corp, with a locally elected board, was created. With its creation, the board also received a mandate from the ministry to manage a 92-bed, long-term-care facility located in new facilities attached to the existing structures in Haliburton and Minden. In addition, major renovations at two sites resulted in a modern, 14-bed, acute-care unit in Haliburton with an attached emergency department, and a state-of-the-art emergency department in Minden.

Responding to the call for an integrated health care model, these two traditional hospital facilities are, as was mentioned previously, physically linked to and share services with the long-term-care facilities in the community. They both have space for physiotherapy, provide a diabetes education program, serve as the base for our

supportive housing program and are linked to our community mental health program. In an effort to stem the flow of doctors from our communities, we have worked closely with local health and business professionals as well as county government in recruitment efforts, including providing space at the Minden site for a medical clinic. Plans for further integration are in the works.

The Haliburton Highlands Health Services Corp has an application before the Ministry of Health for a community health centre in Minden, in space that was designed to accommodate such a service but is currently unoccupied, and expansion of the rehab programs at both sites. Haliburton Highlands Health Services is exploring the possibility of an outreach program utilizing the services of nurse practitioners, and through the mental health program is participating in the homelessness initiative. This organization has provided space for visiting specialists, pediatricians, cardiologists and internists, among others, to hold clinics, bringing health care to the people of our community.

All this has been accomplished in the last seven years by a locally elected board of directors, a board whose members reflect the needs and concerns of the community they serve. In a community our size, the accountability factor is already very high. Be it at the coffee shop, the curling club or the post office, our fellow residents are rarely reluctant to express their views. This high degree of interest is reflected in the fact that our local newspaper regularly sends a reporter to the board's monthly meetings and provides its readers with a detailed synopsis of our proceedings.

This intense interest is also obvious in the support the hospital has received from the community. During the recent construction and renovation program, the community provided \$4.5 million as the public's portion of the \$20-million project. The fundraising and support is ongoing and continues to be robust.

The residents of Haliburton county and the surrounding area served by HHHS value the health care services provided by the corporation.

I appear here today to express concerns about certain portions of Bill 8 that we feel could undermine the authority and dedication of the 14 individuals on the board and the thousands across the province who serve their communities and the health system in general. These are individuals with skills, expertise and experience who are vital to the good management of their local hospitals. These are people who give freely of their time for the betterment of their community and the health system. These are individuals who serve as a conduit between this key part of the health care system and the community, bringing the community's concerns to the attention of the board and explaining to their fellow citizens the hows and whys of health policy.

It is through this interaction that support for the system is built, maintained and grows. It is through this contact between a board member and his or her constituents that others are encouraged to volunteer their time, support and financial resources, all crucial to today's hospital system.

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Aspects of Bill 8 would allow for the direct and unimpeded intervention of the minister in the activities which are now the purview of the volunteer board. The provision that allows the minister to enter directly into accountability agreements with hospital CEOs without the involvement of the board also undermines the reason for volunteer service. It serves the community's involvement and certainly will make our hospitals less responsive to the needs of our local communities.

I won't read the last paragraph. I'll leave it open for any questions that you might have.

The Chair: Thank you, Mr Sansford. I appreciate it. You've left us with about three minutes for questions, so it's going to have to be a very brief one each.

Mrs Witmer: Thank you very much for being here today. I really appreciate it. I hope you'll extend my best wishes to Mr Brezina. I remember one of my first trips as Minister of Health was up to Halliburton Highlands, and I know that the community has worked extremely hard to provide services.

I guess your concern really demonstrates your fear of this shift of power from voluntary boards to the minister. Would that be the overriding concern you have, and the impact it might have on accessibility to health services?

Mr Sansford: Correct. I've lived and worked in large communities and cities as well as rural parts of this country, and it seems to me that, particularly in rural areas, there is far greater interest and involvement in what happens at the local health care organization. If it becomes merely an extension of the ministry, I think the interest and the input from local people will be lost.

Ms Martel: Thank you for taking the time to come here this morning. Your concerns are not new to us. They've been expressed by every hospital board that's come before us.

Let me ask you something else. The minister gave the committee some indication of the changes that he proposes to make in the accountability section. This was done last Thursday. I'm not sure if you've seen a copy of that document or not, but you can pick up a copy over here.

There are two areas I think I want to highlight for you. One, even though the minister has said that we need to negotiate these agreements, in the changes that he has proposed it's still very clear that the minister, and the minister alone, has the power to continue to issue compliance directives or orders. That doesn't sound like a negotiated settlement to me. Secondly, the minister as well can carry out CEO compensation clawback, which would still put your board in a difficult position of trying to be a master while the minister is also a master. Given that those provisions still remain with respect to the direction the minister now wants to take, does that alleviate your concern at all? Or are you still worried about the sweeping powers of the minister, where he can continue to impose orders and compliance agreements and in fact continue to do a clawback in compensation from your CEO?

Mr Sansford: I think our association, the Ontario Hospital Association, has responded to this as well, and we share and support the view that the proposed amendments don't nearly go far enough to allay our concerns.

Ms Smith: Thank you, Mr Sansford, for being here today. Your community is somewhat like mine of North Bay-Nipissing, a fairly broad area and lots of work to do to provide health care to everyone involved.

I just wanted to make sure that you were aware that the minister made a statement on the first day and has provided an outline of the proposed amendments, were you not?

Mr Sansford: Yes, I was.

Ms Smith: You are aware that the proposed amendments include the fact that the accountability agreements will be between hospital boards and the government, and not the CEO and the government.

Mr Sansford: It would be interesting to see how, from a practical perspective, this will unfold. We're still not satisfied that this is satisfactory or sufficient.

Ms Smith: OK. You made a number of mentions of the BC auditor's report. On what basis do you draw analogies between the BC situation and our own?

Mr Sansford: I think that in some respects British Columbia has gone through similar plans that are being proposed in Ontario. I think we might be able to learn from their experience.

Ms Smith: Are you familiar with the BC legislation that was passed?

Mr Sansford: I'm not entirely familiar with it.

The Chair: Thank you, Mr Sansford.

Ms Smith: It's actually quite different.

The Chair: Thank you, Ms Smith. The point's made.

Thank you for being with us today. I certainly appreciated it.

ONTARIO COUNCIL OF HOSPITAL UNIONS, AREA 3

The Chair: Our next delegation is the Ontario Council of Hospital Unions, area 3; Marc Vaillancourt, who is the vice-president of area 3. Welcome. You have 20 minutes, like everybody else. You can use that any way you see fit.

Mr Marc Vaillancourt: Thank you, Mr Chair. Good morning. My name is Marc Vaillancourt. I work at the Toronto Rehabilitation Institute, where I'm employed as a spokesperson. I have been in the hospital for over 17 years. I'm also proud to serve as the president of CUPE local 1156 at Toronto Rehab. I also serve as a vice-president on the Ontario Council of Hospital Unions, representing area 3, which encompasses the greater Toronto area. In this capacity, I represent 9,500 hospital workers, at 13 hospitals, which have a total of 23 different sites. These hospital workers include registered practical nurses, health care aides, housekeepers, dietary staff, maintenance, clerical staff, occupational and physiotherapy aides, and a myriad of other positions—a list far too lengthy to name in the 20 minutes that's allotted.

I would like to preface my remarks on Bill 8 by telling you about the people I represent. Their average age is 49 years old and, on average, they have worked in the health care system for 17 years. Yet all these people, who come from diverse ethnic and cultural backgrounds, different educational levels and very different life experiences, share several common traits.

The first trait that they share is compassion. Our members are compassionate, caring, nurturing human beings. They have to be in order to do the work that they do. We do the work that most Ontarians would consider disgusting and demeaning. Our members are exposed on a daily basis to illness, disease, injuries and death. They work in very difficult conditions and deal with these hardships because the most important thing to the large majority of health care workers is the patients we provide care for.

The second commonality among health care workers is fear. Our members look west to British Columbia and see the devastating effects of Bill 29, which has resulted in the layoffs of over 6,000 qualified, predominantly female health care workers. In addition, another 12,000 positions face being contracted out in the next two years. These positions are being contracted out to multinational corporations that, in turn, offer the jobs at half the wages, with few or no benefits or pensions. This should be considered an affront to all working people in this country.

In recent contract negotiations, the Hospital Employees' Union in British Columbia offered a \$3-an-hour wage cut, as well as a week's reduction in vacation, reduced statutory holidays, reduced sick time and other benefit concessions. The concessions were refused by the employers as not cutting deep enough. The wholesale contracting out continues unabated.

Next door to Ontario, the Quebec government, through Bill 27, removed successor rights from unions and made unions illegal in home daycares and in retirement homes. The Quebec government is now in the process of contracting out health care and other public services. Given Premier McGuinty's comments that Ontario and Quebec need to work closer together, we find that it is indeed distressing to our members in Ontario.

This brings us to Bill 8. When Minister Smitherman rose in the House and introduced the bill, he emphasized his government's support for medicare, the Canada Health Act, and for the prohibition of two-tier medicine, extra-billing and user fees. Our members applauded. Indeed, there was a collective sigh of relief the day the Liberals were elected. After years of downsizing through layoffs and attrition, we had hoped that the new government would respond to the wishes of the large majority of Ontarians.

However, when the bill was examined, it revealed several disturbing features. Specifically, I'd like to talk about part III of the bill. The bill spoke about accountability agreements and compliance directives. It gave the Minister of Health and Long-Term Care unprecedented powers. The minister could, in effect, order anybody in the health care system to do anything at any time. That's

in section 22. The act gives the minister the power to order material changes to a person's terms of employment, including a reduction or variation in compensation and benefits, to deem that that change is mutually agreed to and remove any rights to payment or compensation. That's in section 27. It also applies, with necessary modification, to a contract or agreement for services: subsection 27(2). Where funding is reduced, varied or discontinued, which, incidentally is the rationale for most health care cuts and layoffs, it is deemed to be mutually agreed to and does not entitle any payment or compensation. That's included in section 28.

Another area of concern is the insulation of the government against any legal challenges or an obligation to provide compensation, as in section 30. All of these sections were interpreted by our legal opinion as having the power to open collective agreements, gut job security provisions and open the doors of Ontario hospitals to the same type of mass layoffs and privatization being suffered in British Columbia and that are planned in Quebec.

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Since the introduction of the bill, Minister Smitherman has been quick to deny that it is the intent of the government to use Bill 8 as a tool that would result in the same type of massive cuts and privatization inflicted in British Columbia. He has been very clear that unions and collective agreements are not to be party to accountability agreements or compliance directives, and that this would be made explicit in the amendments to the bill. In his address to this very committee, the minister said, "... labour unions may tell you that the accountability agreements will allow for opening collective agreements. This bill does not reduce or change any of the protections that currently exist in any of our labour laws. It does not allow anyone subject to an accountability agreement to reopen collective agreements. Unilateral wage rollbacks and unpaid days off might be the record of a previous government, but the suggestion by anyone that Bill 8 enables this is an act of partisan-inspired fiction." The minister has since tabled some potential changes to the bill; however, they won't be released until after this committee ceases public consultation.

Why are the unions and our members still upset? In his address to this committee, the minister said that the bill should not open current collective agreements. Given that all health care collective agreements, never mind what union you're in, are expiring this year, it is hardly the reassurance that we seek.

This government promised to eliminate P3 hospitals, yet delivered instead the same thing that was initiated by the previous government. The only change is that at the end of the lease, or mortgage period as the Liberals prefer to call it, the hospital is not owned by the contractor. Yet hundreds of unionized positions will be contracted out from these two hospitals being built.

This government is using the British model of P3 hospitals. These are hospitals that contain fewer beds and staff. The reason? It costs more to operate. Borrowing

costs for the private sector are higher than those of government, and those costs will be passed on to the taxpayer. With the two current P3 hospitals in Ontario, over \$1 billion in Ontario tax dollars will be turned over to transnational corporations. Given that the required profit margin for these corporations can be up to 25% to 30%, are we going to be looking at \$250 million to \$300 million in Ontario tax dollars being taken by these corporations for profit? There are currently two P3 hospitals planned; however, we have been advised that there are potentially another seven in the works. We have also been advised that future hospitals will be built using the P3 model.

This government promised to eliminate for-profit MRI and CT clinics, yet these are conspicuously missing from Bill 8, a bill that purports to protect a single-tier health care system.

As a member of the Ontario Council of Hospital Unions bargaining team, which was successful in negotiating the first freely negotiated collective agreement in OCHU's 20-year history in 2001, I see Bill 8 as an impetus to the upcoming negotiations. Neither the Ontario Council of Hospital Unions nor the Ontario Hospital Association will be able to bargain freely if the government is lurking in the background, threatening accountability agreements and compliance directives.

Hospital workers have had a difficult time in the past decade. Boy, have we had a difficult time in the past decade. With each fiscal crisis, our numbers drop and our workloads increase. Despite these difficulties, our productivity has increased. We've had to learn to do more with less, yet we still put patient care first.

Our members are aging. They want nothing more than to finish their careers and enjoy their well-deserved retirement with dignity. The sad reality is that health care workers don't believe the reassurances of the minister. Reorganization within the health care system means that the services we are proud to provide are inevitably deemed too expensive. We are told that we provide hotel services and that the health care system can't afford us.

It was less than a year ago that health care workers in Toronto were acclaimed as heroes. It is our concern that Bill 8 is the first step to make us scapegoats for the inability of provincial and federal governments to adequately fund the system that Ontarians hold dear. Thank you.

The Chair: Thank you, sir. You've left us with about two minutes each for questions, starting with Ms Martel.

Ms Martel: Thank you for being here today, I want to focus on compliance directives. You quoted the minister, who said, "It does not allow anyone subject to an accountability agreement to reopen collective agreements." He didn't say anything about compliance directives.

I want to go to the same question that I was pursuing with Mr MacDonald. My concern is that the minister won't have to use a frontal assault through a collective agreement but will in fact use the compliance directives in order to effect change that could be negative for the

people you represent. So if the minister says to a hospital, for example, as part of an accountability agreement, "We think you should amalgamate your housekeeping," or "You should contract out housekeeping," your members are going to be affected by that because if the service is contracted out and there are no successor rights—and frankly, even if there are—they may lose their jobs. What do you think about the fact that there is no reference to compliance directives in this, and that impact on trade unions? Are you concerned that in fact by a back door you may lose positions anyway?

Mr Vaillancourt: That is precisely our concern. For the minister to say, "We're not going to force unions to enter into compliance directives, agreements or anything like that," really doesn't mean a lot to us, because we're the ones who provide the front-line service in hospitals. Ultimately anything—a compliance directive that calls for a merger of services or, in the case of BC, calls for financial targets that need to be met, ie, 5% or 10% cutbacks—falls on the back of unionized workers. We are the ones who pay the price.

Just to go back, the minister said that current labour laws protect us, but if we look at what happened in BC and in Quebec, current labour laws can be changed very easily to remove successor rights. We have a majority government. The fact that we're not being directed by the minister directly doesn't mean that we're not going to be affected, because anything that affects health care ultimately trickles down and affects us directly.

Ms Martel: In the hospitals you represent, you would have seen examples already, I suspect, of amalgamations or contracting out of some of these services.

Mr Vaillancourt: Amalgamations, interdepartmental mergers, quality assurance projects. There have been all sorts of things. When we talk about the stress that we've been under—there is no job security in hospitals. We have a collective agreement that gives us, perhaps, five months' notice of a layoff, but if that's an impediment to anything being done, that could be easily removed.

Ms Smith: We heard this morning from Mr MacDonald, who I think works with you. He made some similar points. I had a couple of questions for you. With respect to BC's Bill 29, in what way do you see that as being a mirror image or in some way reflected in Bill 8?

Mr Vaillancourt: I'm not going to go to the point where we're saying Bill 8 and Bill 29 are in essence the same thing, because they're not. What we look to is that British Columbia started this process two years ago. We view Bill 8 as the beginning of the process. We have two of the three largest economies in Canada, coincidentally all with Liberal governments, which are either doing or are in the process of commencing major cutbacks to health care and public service. Our members are the ones who always bear the brunt. You don't hear CEOs saying, "We're going to take a \$300,000 pay cut." No. What they do is lay off 10 housekeepers, who make \$28,000 or \$30,000 a year, in order to achieve those goals.

So the comparison is there not because the bills are similar; obviously they're not. Our concern is, that's the

road that we're heading down. BC is setting up the road map for this government.

Ms Smith: OK. In your presentation, you acknowledge the statement by the minister that Bill 8 does not apply to collective agreements or to trade unions, but you do say in your statement, "All of these sections were interpreted by our legal opinion as having the power to open collective agreements, gut job security provisions and open the doors of Ontario hospitals to the same type of mass layoffs" as BC. Are you referring to the Sack Goldblatt Mitchell legal opinion that Mr Hurley provided to me last week?

Mr Vaillancourt: I am.

Ms Smith: In that legal opinion, I don't see anywhere where it says anything like that. The only references I see are that Bill 8 could potentially extend "to the overriding of collective and other negotiated agreements," and at another point it says, "A trade union, for example, might well qualify under the broad definition of health resource provider, or in any event, could potentially be prescribed as a person or entity required to enter into such an accountability agreement."

Now that you've had these assurances from the minister that they don't apply, does that go some way to quell your fears from this legal opinion you received?

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Mr Vaillancourt: Respectfully, I would say the Liberal government told us that P3 hospitals no longer exist, and yet all they did was slightly tweak the agreement; P3 hospitals are in existence. The Liberal government told us that for-profit MRI and CT clinics would be taken out, and yet there's nothing in Bill 8 about that. There's a credibility issue here.

The Chair: Mrs Witmer.

Mrs Witmer: I think we've heard the same type of anxiety and concern from many others who work in the health sector. Health employees seem to be quite distressed about the possible implications, and I guess a lot of it is based on the fact that these changes did happen in BC, even though people were not expecting them and there was no indication. I think you have every reason to be concerned, because we have seen broken promises, and certainly, as you have acknowledged, anything is possible with a majority government.

I guess I would ask, what do you need to see in this bill that would give you the reassurance that this is not going to lead to massive layoffs? What protection do you need in here?

Mr Vaillancourt: It's a good question. I think what we need to see—our concern is that while unions are excluded from the bill—

Mrs Witmer: You are directly, but not indirectly.

Mr Vaillancourt: Directly excluded, but indirectly we bear the brunt of any downsizing, of any reorganization, of any re-engineering that occurs in health care.

Mrs Witmer: That's right.

Mr Vaillancourt: It's the trickle-down theory. It happens all the time. We've lived through it for 10 years. We're sitting here right now looking at a mass exodus of

health care workers from the system at the end of 2005, because the pension plan is offering a temporary bridge that expires at the end of 2005. Our concern is that those positions will be lost through attrition. These people go out, and they don't get replaced.

The Chair: Mr Vaillancourt, your time has expired. Thank you for joining us here today. It was appreciated.

DONNA BUCK

The Chair: Our next delegate is Donna Buck. Would you like to come forward and make yourself comfortable?

Ms Donna Buck: I have a few issues I was going to discuss. I didn't realize it was going to be quite so formal.

The Chair: Well, we're not as formal as we might appear. You've got 20 minutes. You can use that 20 minutes any way you see fit. At the end of the formal part of your presentation, we will ask you some questions, and that time will be apportioned among the three parties. If I were you, I'd just relax and tell us what you came here to tell us. It's a quarter to 12, and your time will expire at five minutes after 12.

Ms Buck: Thank you.

The Chair: Thank you, and welcome.

Ms Buck: Government is the pillar of our society, and it creates the infrastructure. It must truly become the force that helps us to understand and regulate how we are cared for.

The things I wanted to discuss would be an increase in the use of holistic health, OHIP billings, more accountability by specialists for services rendered, caffeine's effect on society and control of air pollution. I'm not really certain whether these are under your—

The Chair: It's your 20 minutes, and you can pretty well talk about anything you like, as I understand the rules. But I would concentrate on areas that are directly related to the bill, if you could.

Ms Buck: Do you think any of those relate to the bill?

The Chair: Let's find out. Why don't you start talking, and I'll soon tell you if they don't.

Ms Buck: You can cut me off any time.

The Chair: I probably won't. It's your 20 minutes.

Ms Buck: I would like to suggest that invoices for OHIP billings be sent to every user so they can see the cost of these services, thus making medical costs more transparent. Sending out bills with a list of services rendered and amounts charged enables everyone to judge on a personal note whether the services rendered were worthy of the price charged. If I have no invoice, the service has no defined value, and I may not put a value on it. We'll appreciate the service more.

Also, we may demand more of it. If I went to a doctor's office and was given only five minutes, I may feel that's OK. But if I knew the monetary cost of that visit, I may feel I should have gotten more for the money paid. I would not go to a store and make a purchase without a clue as to the cost. That would be irresponsible.

If everyone knew the cost of their visits, they may feel more accountable in keeping the cost down and we may respect the doctor's advice.

In regard to health care and integrating holistic health into health care, conventional medicine is in a creative double bind, in that only if it feels it knows the cause and effect can it deal with a problem. The problem is, in some realms it is guessed that medicine knows only about 12% of all there is to know about the human body. In emergency situations or very critical situations, conventional medicine reigns supreme. But in less dramatic situations, traditional medicine may be more effective as preventive medicine and when the body needs help in healing itself.

Does conventional medicine feel threatened by the advances of traditional medicine? Two camps: traditional and conventional. Traditional had been in place for many years, then came conventional—for example, surgery, vaccines and pharmaceuticals—which gives much more immediate results. With conventional, everything is immediate. The diagnosis must be evident and the solution quick and visible. The problem is that if a cause-and-effect relationship is not evident, then the problem is a mystery, a diagnosis cannot be made, and nothing can be done.

Traditional is much slower acting, needs more attention paid to the patient and is less invasive. The patient is far more central to the cure. It is time-consuming but cost-effective. Solutions do not always fall into the cause-and-effect mode. Sometimes the solutions are just as mystifying as the workings of a computer.

Whereas conventional medicine may be likened to working with a typewriter, traditional medicine works more like a computer. Push Alt-Delete and something unexpected happens; put pressure under the shoulder blade and a neck muscle relaxes. Reactions happen without there being an evident connection.

A case in point is acupuncture. Meridian points were mapped by the Chinese thousands of years ago and have been found to be miraculous, allowing surgery to be performed without anaesthesia by inserting pins into the body. It wasn't until the 1990s that acupuncture was found to be scientifically plausible. Through intuition, trial and error and hard work, the Chinese were able to plot an electrical energy system of the body. At one time, electricity was seen as mystical, something to be feared, incomprehensible, energy travelling through wires. Now, even though we don't understand it, we don't care; we just know it works. Most of the alternative is unseen and incomprehensible, but it works. It relies on a visceral cause and effect, not a tangible cause and effect.

If traditional medicine can alleviate pain from a person who would otherwise continually suffer from excruciating pain all day long, shouldn't we try to employ it for the sake of those who are suffering? If chiropractic and acupuncture can alleviate the need for someone to undergo the dangers of having their body cut open and fiddled with, which always poses a risk, shouldn't we encourage these alternative solutions? Alternative medicine also advances more measures to help prevent diseases from entrenching themselves in the body.

The Ministry of Health should encourage the use of holistic medicine through offering OHIP coverage for its use, although if government funds it, then all therapies should have their own regulating bodies.

These are a little bit disjointed, but—

The Chair: I'm not finding it disjointed at all. I'm actually enjoying your presentation. Keep going.

1150

Ms Buck: Controlling our environment is very important. Could there be a special department set up that could effectively take down boundaries between ministries and levels of government so that issues such as air pollution, which affect everyone's health, could be fought and alleviated? This department could take measures to increase public transportation, lower car emissions, reduce industrial pollution etc. If one group had one task, maybe it could be achieved.

The next one is completely different: I feel that caffeine is as major a drug and social problem as smoking. I worked for 10 years to get caffeine out of the schools. The furthest I got was for the Toronto Board of Health to do a report on the effect of caffeine on children. Caffeine is now out of our elementary schools. Whereas we all know the effects of the drug caffeine, how could we have allowed it to be sold to our children in the most sacred of institutions, our schools? Nowadays, children are on antidepressants and are suicidal. Could the drug caffeine be part of the problem? Caffeine is known to cause anxiety, sleeplessness and, eventually, depression.

The problem now is that it's still in our high schools. If our kids knew the truth about what colas are doing to them, would they still drink them? We need to be the ones to explain the true effects of caffeine on their bodies now. In fact, do adults truly understand the effect of the drug caffeine?

Another one: I would like to see more accountability and responsibility taken by specialist physicians, just for that fact that if your problem does not register within the narrow confines of their specialty, then you have to go back to your GP and find a new route. This is where I think alternative medicine could be effective, in that it looks at the whole person and can find clues to the root problem of a malady, and then send them to the proper specialist.

That's it.

The Chair: Very good. You did a wonderful job. You've used up about eight minutes, which leaves each party four minutes. I'm going to start the questioning with the government side.

Ms Smith: Thank you, Ms Buck. We really appreciate your being here to provide us with your views on Bill 8 and on health care generally. As you know, we've taken the unusual step of going forward with this legislation to committee after first reading, which will allow for more input and for us to come back with a better piece of legislation, we hope, at the end of the day. We appreciate people like you coming in to provide us with your insights.

One of the things you touched on was a holistic approach to medicine and looking at a broader scope of

medicine. Perhaps you could just elaborate on that for us a bit and how you think we can incorporate that into our health policy.

Ms Buck: I think that in a lot of ways holistic medicine can diagnose and see the whole body, rather than having a specialist who sees one part of your body. But if there is no cause and effect and they can't diagnose it, then it's a mystery, whereas alternatives and holistic would look at the whole body. Sometimes something that's happening here may be caused back here. If somebody could just look at someone's body and say, "Yes, we think it's there, but in fact it's a referral; it's really a problem down here," they could make a decision as to where you have the problem and then go to a specialist, rather than, "You have a pain down here, but really it's part up here." If you go to see that specialist, then they won't be able to find it. If they could get a more holistic view of the body, you would save money, because you wouldn't have people going to one specialist and then another and another, and really the problem is not where they think it is but somewhere else.

Ms Smith: Sure.

I think one of my colleagues has a follow-up on that.

Ms Wynne: Thank you for your presentation. My experience of allopathic, or conventional, medicine is that it's very institutionally based and very reactive. Is that your experience? When you talk about cause and effect, unless we can find the cause, we don't know how to treat.

Ms Buck: It's very scientific. It's like going back to the 19th century. We're still back there with medicine, in that we see it as cause and effect. It's like locomotives: They run this way because we can see there's a cause and effect, therefore we can make them run.

Ms Wynne: And we think we can draw direct lines, right? We think we understand. Do you think that if we could move that institutional base into a more community-based model, the kinds of practices you're talking about would have a better chance of coming to the fore? What we're trying to do is move to a community-based model of health and away from a deeply entrenched institutional model.

Ms Buck: Possibly, yes. When you have a problem, somebody could actually treat a person as a person and find out exactly what the problem is, rather than just analyze them on cause and effect, which is a kind of science that's like a computer. You look at the computer and say, "How does it work?" That's like the body; we only know so much about the body and how it works. We only know so much about the computer and how it works. I think holistic goes more into it.

It's like trial and error. Following the meridians, if you do this—or like homeopathy. If you take one drug and it does something, then you know that's it. It's trial and error, but you don't really know, scientifically, it's right. What is the problem with trial and error? If you can get a solution by trial and error and you've got something that's good and it helps people, then shouldn't that be deemed as fine? We don't understand it.

The Chair: I know you are on a roll, and I hate to cut you off there, but we have to move to the other party. Ms Witmer?

Mrs Witmer: Thank you very much, Ms Buck, for coming and giving us your views on holistic medicine. I think there is certainly lots of information there that people need to continue to consider. I don't have any questions on Bill 8.

The Chair: Mr Arnott, you're fine? Ms Martel.

Ms Martel: I want to thank you for coming and giving us some of your perspectives with respect to health care, particularly your views about alternative and traditional medicine. I don't have any questions with respect to the presentation either, but thank you for taking the time to be here today.

The Chair: Thank you, Ms Buck, for coming today. We do appreciate it. You did wonderfully.

CANADIAN CENTRE FOR POLICY ALTERNATIVES

The Chair: At this point in time we were scheduled to hear from the Canadian Centre for Policy Alternatives. We're not exactly sure if the gentleman is in the room—you would be Armin?

Ms Armine Yalnizyan: I'm Armine, yes.

The Chair: Armine, I'm sorry.

Ms Yalnizyan: It's OK. It's an easy name to get wrong. You wouldn't believe what they do to my name.

The Chair: Well, I'm not even going to try; I'm going to let you introduce yourself for Hansard, if you would. You have 20 minutes, like every other presentation. You can use that any way you like. At the end, we'll apportion the time that is left over amongst the three parties. I've got about two minutes to 12 and the time is all yours.

Ms Yalnizyan: Thank you very much. My name is Armine Yalnizyan. I'm an economist based in Toronto. I'm a research associate with the Canadian Centre for Policy Alternatives, which is based in Ottawa. I am the surprised and honoured first recipient of the Atkinson foundation award for economic justice. I have been using that award to look at health policy reforms in the country.

First of all, I want to applaud the work this committee is trying to do to protect health care. Protecting health care in countries all over the world is the key policy issue right now, and it is a genuine challenge.

I'm not going to read from my text, which I will have distributed. I hope you're interested enough in our exchange to follow the argument and look at it later. I'm not going to vent or dwell overlong on the feelings of Bill 8 as I see them; undoubtedly that will emerge from part of our exchange. I'm going to focus only on the amendments that I think are key to move this bill in the direction that you say you want to go in, which is to protect the future of medicare and block two-tier care, or what I like to identify as the passive-aggressive commercialization of health care.

Yesterday's meeting of provincial premiers and territorial leaders was, how do you say, disheartening.

Premier Klein is still talking about opting out of the Canada Health Act, and the communiqué from all the premiers and territorial leaders announced that they gave medicare and the principles of the Canada Health Act a 10-year prognosis without more massive funds from the feds. This sabre-rattling is not productive, to say the least. It also invokes a feeling of déjà-moo: the feeling that you have heard this bull before.

The principles of medicare are under attack at the moment. You are trying to protect them through this bill. I do not believe this legislation is the key tool for that, but I am going to be focusing on the amendments to ensure progress in that direction. I'm going to point out for you, in very stark terms, why the stakes are so high that you do amend this bill and move in the right direction.

First, where is the pressure on medicare coming from? I believe the pressure is two-fold: first of all, the sustainability argument, where you have costs growing at roughly double the rates of revenue growth for the foreseeable future, and secondly, from waiting lists, that whole sentiment out there that is, "Let me jump to the head of the queue if I can afford to pay for it."

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All of you in this room probably know that in a few months' time at the Supreme Court of Canada, the Chaoulli case will be heard. That will be one of the major tests for whether queue-jumping will be viewed as possible under the Constitution and whether in fact people's right to be able to purchase care when waiting lists are too long is a constitutional violation.

This bill does not deal with the role government can play in containing those costs—the number one cause of the unsustainability—more effectively. It doesn't deal with this government's comparable advantage in the marketplace for health care due to its shear size and its ability to purchase: economies of scale from borrowing funds, necessary capital, investments; its ability to set prices and deals on prices and quantities in drug procurement, but also in quality, for example; and in providing the efficiencies of a single-payer model.

I'm going to focus primarily on part I of this bill, which refers to the health quality council, and part III of this bill, which refers to the accountability principle.

The function of the health quality council is absolutely key and can be amended to make it speak more dramatically to what this government can do to ensure better access to health care.

The monitoring function of the council at the moment includes the ability to collect, use and disclose patient information for reporting purposes. I'm going to suggest to you that you can amend the bill in this section to also include the ability to collect, use and disclose information about how public funds are used in all of our institutions in health care—in hospitals, long-term care, community health centres—to see very clearly how it is that best practices are offered and where the greatest cost-efficiencies are, not just in not-for-profit and for-profit modalities of providing care but who is doing what in the

best possible way. When we see how public funds are being used to deliver care, we can then start talking to the public about what are the best modalities of care and where we can achieve real improvements in how we deliver care for the best value for money.

That sort of monitoring function can also show us the degree to which our taxpayer dollars are facilitating the shift toward investor-owned facilities. I think it's absolutely clear that taxpayers are very concerned about their value for money, and they don't want to be spending money on unnecessary things. If we are spending money on profits and shareholder dividends, we want to be able to know to what degree this is increasing or decreasing over time and whether, on net, we are getting better value for money because those facilities are able to give us either greater, faster, cheaper service or a higher quality of care. Right now we are being asked to do this as an article of faith, and I'm asking you to use the council's ability to collect, use and disclose information to help the public understand where we get better value for money.

I also believe that the council's reporting function should be the home of long-term planning on the key things that we can do to reduce waiting lists. There are three key things we can do to reduce waiting lists: We can have a better strategic plan on how we are investing capital; we can have a better strategic plan on how we are preparing for the health human resources shortages that are coming on stream in the next five to 10 years; and we can have a better plan for how we have information flows in the system. We all know that the need for electronic health records is very key, but we really have very poor information flows between different elements of the health care system as it's currently funded. This leads to blockages and unnecessary utilization of acute care, which is the system of last resort of care—our hospitals and emergency rooms. That's being used as our front-line use of care, which is of course the most expensive form of care. The way we are going to shorten waiting lists is by having plans on reducing waiting lists, not simply by declaring that two-tier health care should be blocked with this kind of legislation.

The stakes are incredibly high. There is a lot more money in the system than there was. When the previous government started managing the health care budget, it was spending about \$18 billion a year. The previous government poured in new resources toward the end of its mandate. We now spend \$28 billion a year, and rising. That's \$10 billion more a year, yet waiting lists are more of a problem than ever and the sustainability of the system seems to be genuinely in jeopardy. In addition, we had a health accord between the provinces, territories and the federal government last February. That accord alone guarantees this province will receive \$11.3 billion more by 2007-08. So we are talking about many billions more dollars coming to health care. I can tell you that the taxpayers and the general public are very concerned, as are many of the Premiers, that this money is going into a black hole. Why? We don't have a plan on how to use the new money to buy improvements in the system.

Yesterday, our Minister of Health and Long-Term Care, Minister Smitherman, gave the hospitals \$385 million more to deal with the deficits in hospitals—with strings attached, he said. There are performance requirements. There is an acknowledgement that they need to reduce waiting times and hire more full-time nurses. I'm asking you, how does this money actually lever waiting times and more nurses? There are no plans on how those people will be hired and what the interim steps will be to reduce waiting times.

This situation leads me directly to the second set of amendments I would propose, which go to part III of the bill, accountability.

Again, what is the plan? Just more money will not do. You need medium- to long-term strategies on public financing of capital expansions, again, with the greatest value for money in mind. You need to improve information flows to minimize the supply blockages in the system; not just electronic health records but more posting of what's going on in the system, who is being moved where, which doctors, which specialists, which institutions have the longest waiting lists, which have the shortest ones, so we can move people more effectively into the appropriate levels of care and to the appropriate caregivers.

We need better training, upgrading, certification and utilization of our team of health care professionals. Right now you have no plan for how you are going to hire 8,000 more nurses, which is what you've said you want to do. This is a problem not just at the Ontario level, this is a national problem.

The real issue of course is not just capital and labour, but technology. That's true in every endeavour of providing a better service, and the technology I have in mind here is how we mix our capital and labour. That technology goes to the heart of primary care reform. We are not using the mix of people we have effectively. We are relying on the most cost-heavy institutions in our system and the most cost-heavy forms of labour, which are our doctors. Doctors are in a global labour shortage right now, as are nurses. Surely we can come up with more strategic ways of using our full-team complement of health human resources.

The system is indeed too expensive and will not be able to continue in the way it is. I guess when the Premiers and the territorial leaders talk about the lack of sustainability, it goes to the heart of how we are using that money. I'm hoping this government will seriously look at the way the public dollars for health care are used and seek to rebalance between the different ways we use health care in that public purse. More money is necessary but it's not the only answer.

I'm reminded of the Rolling Stones line, "You can't always get what you want, but if you try, sometimes you just may find you get what you need." I'm hoping this government will actually try; not just get the service providers to be more accountable and have performance requirements, not just get the federal government to try harder, but itself be more accountable to the public on how public dollars are spent.

The federal government, through the Romanow report, the Kirby report and a new political leadership, has already signalled its desire to work in a more co-operative manner with the provinces and territories, especially on the crucial issue of health care. I point to the national human resources strategy that is underway right now and the common drug review, which are national, not federal, initiatives but are spearheaded by the federal government. Ontario is impeccably poised to play a leadership role to make that co-operation happen in areas that would truly make a difference to the sustainability of public health care.

Let me close by saying that while I applaud this government's stated desire to protect public health care, which I believe is in all of our interests, this legislation falls very far short of that lofty goal. But with strategic planning embedded into this legislation, using the council more effectively and shouldering some of the duty to be accountable to the taxpayers of Ontario, with clear targets for improvement and standards for care, there is much that can be done to protect medicare provisions for today's citizens and for the citizens of tomorrow. Thank you very much.

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The Chair: We're going to start with the official opposition this time. You've got about two and a half minutes, Mrs Witmer.

Mrs Witmer: Thank you very much, Armine. This has been one of the most interesting submissions I have heard in the course of the discussion on Bill 8. I really appreciate the thoroughness of your presentation and also the recommendations you've provided. I found it interesting to hear you speak about the money we had invested in health care. It really was huge, but it was not something we usually heard. We usually heard from the opposition that we weren't spending enough. But I would agree with you that spending is not going to always improve the outcomes for individuals.

Having made this presentation today, what do you see should now happen with Bill 8? You're basically saying that although the government is well-intended and wants to do the right thing, this bill is not going to achieve it. So what should the government do? We have a bill with a preamble, accountability provisions. What to do?

Ms Yalnizyan: Again, I think the three sets of amendments that need to be made are in parts I and III: in part I, that the health quality council be given the explicit duty to collect, use and disclose information about how public money is used in all our facilities, both investor-owned as well as private not-for-profit, so we can see how the money is being used and ensure that the best value for money is taking place; and second, that it is included in here that the monitoring function of the annual reporting function of the council does include and embed long-term strategies for how we are going to finance the necessary expansions.

I think one of the great problems of the previous administration's pouring money into the system was that indeed a lot of money went into private for-profit care

with no indication that we got value for money for that extra expenditure. I would like to see this government take a look and make sure that extra expenditure is merited, in terms of the value for money we get.

I don't see any evidence of that. Romanow called for it. We didn't see any of it in the Romanow procedure. I think this is an opportunity to get the council to have some teeth to say, "Where's that money going? Is it good value for money? Do we revert to a not-for-profit modality, and what are the implications if we do?" and use that for strategic planning.

For example, in a previous presentation I made to the standing committee on finance and economic affairs during the pre-budget consultations, I indicated that if you could go to public financing rather than the P3 modality for funding the necessary capital requirements that the Ontario Hospital Association indicated are up and coming in the next three years, under the most conservative assumptions of what those deals look like, you could be saving the taxpayer money that could then go into training and upgrading nurses. In particular, the 8,000 nurses that you say you want could be achieved in the next eight- to 10-year horizon just from publicly rather than privately financing those initiatives. If we're going to be paying more anyway, why don't we pay to actually get more service, not just more payments to capital?

The Chair: Ms Martel.

Ms Martel: You're making my point; I love this.

Ms Smith: Such a nice segue for you, Shelley.

Ms Martel: Exactly. Here I go. I was going to talk about Romanow, because frankly, through that exercise the private sector did have the opportunity to come forward and provide specific evidence that for-profit health care is cheaper, more cost-effective and gives better health outcomes. I think Romanow was really clear there was no evidence from the private sector that any of that was happening. So I don't see why we would go any further down the road of private sector health care than we already have, which takes me to the bill.

Of course the bill talks in glowing terms about medicare. Who could refuse to deal with the sentiments that are outlined in the preamble? But if you've got a preamble that talks about saving medicare and you have a government that's going down the road of P3 hospitals, private for-profit CAT scan clinics and competitive bidding in home care, I don't see how we're saving taxpayers' dollars, and I don't see how we're using taxpayers' dollars in the best way we could.

Maybe you can comment again, certainly about P3s, because it's interesting that the government talks about public administration, public delivery, but they don't talk about public financing and how important that is. Also, maybe you can comment about competitive bidding in home care or the for-profit MRI and CAT scan clinics. Do you think we should, as the government promised, be moving that technology back into the publicly funded hospital system?

Ms Yalnizyan: I'm not trying to throw cold water on this, but I understand that the government, not just the

opposition, is interested in looking at all options for saving health care, and I understand it is trying to make evidence-based decisions. So I would point to the submission I made to the finance and economic affairs committee. I'm happy to submit that to the clerk of the committee and circulate it to the members. It goes in more detail to what you are speaking to, Ms Martel. But I want to indicate that you cannot have a piece of legislation like Bill 8, where you say you want to protect health care and you want greater transparency and accountability, and yet you still keep these P3 deals under wraps. We still don't know what it means to be a mortgager rather than a lessee.

My greatest fear, now that we are mortgagers of these P3 hospitals and still don't know the terms of the agreement, is that we as taxpayers are now liable for repairs and maintenance, right? That's what a mortgager does. A lessee has the lessor do those repairs and maintenance. What's the nature of the deal? Can you please tell us what we've bought into? If those deals have not yet been confirmed, can we, as the public, please have the options you have considered for financing?

In a period where we've got a 45-year low in interest rates and where our public borrowing requirements by this government, thanks to the previous government, have been dropping for the last 10 years, there's no better time to invest publicly, save the taxpayer dollars in unnecessary costs and use those tax savings to actually hire more people, which is the real cause of waiting lists. It isn't just about where we're spending the money but how efficiently we're spending the money. My key concern, as an economist, is that we are getting value for money and that we are not wasting scarce government resources.

The Chair: Ms Smith.

Ms Smith: Thank you, Armine. That was just a fabulous presentation. We really appreciate your being here and bringing your expertise to bear. I want to congratulate you on your award, and we appreciate the Atkinson Foundation's providing us with your time and expertise on health care, which is fabulous.

You talked about the fact that you thought the council should monitor, collect, use and disclose information about how funds are used, and you talked about looking at best practices and finding ways to improve. I agree that's a great strategy. That's what I'm doing in my long-term-care reviews: actually going into the homes, looking at them and figuring out why, with the same funding, some are better run than others. What magic wand are they waving? So I do see your point of view on that.

I also noted your statement about the \$10 billion that was added by the previous government with no discernible benefit, no improvement in waiting times. One of the things I did want to ask you about specifically was the accountability agreements in section 3. Do you agree that they will go some way to providing accountability to taxpayers on how our health dollars are spent and will go some way to ensure we have proper spending of our tax dollars, our investment, in health care?

Ms Yalnizyan: Excellent question. The \$10 billion: It's easy to point and say, "Why didn't we get a better bang for our buck?" But the system is under huge cost drivers. We spend \$2.5 billion in the Ontario drug benefit plan alone, and those costs are outstripping everything else in terms of cost inflation. We buy retail; we don't have a procurement strategy for ODB. There's the common drug review; we're not participating in that at the federal level. Why are we adding drugs? The previous government took a look at three-year price-quantity volume agreements. It was a great initiative; it's fallen in the water. You should re-seize that opportunity to get some kind of control over what you're spending for these drugs, but also make sure the new drugs that are coming on are cost-effective.

Similarly, in the situation of a global shortage of doctors and nurses, you are going to have cost-push. That's just the nature of the game. So are you using doctors and nurses in the most effective way possible, or are there other members of the health team whom you could be using more effectively?

As you pointed out, the same amount of money buys very different types of care in different types of institutions. Can we not look deep into these organizations and see what works best? There is no magic. It's not for-profit or not-for-profit that delivers high-quality health care; it's something about the way these labour and capital inputs provide a better outcome.

With respect to accountability, I believe you cannot force accountability out of your service providers unless you yourself as a government are willing to set standards below which you do not allow service provision to fall. For example, in long-term care we lost our standards on staff-to-patient ratios. We need standards. We need minimum expectations that the taxpayers, who are spending \$28 billion a year and more, can rely on: This level of care will be guaranteed. I'm not talking about timeliness; I'm talking about quality of care and that you have clear and explicit goals toward which you want to move.

I don't believe the time issue in waiting lists is the critical issue. I think the issue is access and supply. We are heading toward real shortages in both capital and labour. You need plans on how you are going to address that, and those plans have to be made public: What is your capital financing plan, what is your health human resources financing plan, what is your plan on making the health care industry less of a cottage industry, as Senator Kirby would refer to it, and getting us information-connected in a way that works? There are no plans for any of these things. That's where the accountability comes from.

The Chair: Thank you, Ms Yalnizyan. Unfortunately, you're time has expired, but we did enjoy your presentation and appreciate it.

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YORK CENTRAL HOSPITAL

The Chair: Our next delegation this afternoon is from York Central Hospital. We have with us Jim Kirk, the

board chair, and Bruce Harber, the CEO and president. Would you like to come forward and make yourselves comfortable.

Mr Jim Kirk: Thank you, Mr Chairman and members. My name is Jim Kirk, and this Jim Harber, the president and CEO of York Central Hospital.

The Chair: You have 20 minutes. You can use that any way you see fit. At the end of the 20 minutes, we will share the time remaining amongst the three parties to ask you any questions.

Mr Kirk: Thank you. I've had the opportunity to listen, read and, in fact, watch the parliamentary channel over the last couple of days. What I take from that is, what we want to tell you you've already heard several times. But let me tell you, as an overview, that we support the effort being made to find new ways to deliver health care. Yes, we support the health quality council. Yes, we embrace the five key principles of the Canada Health Act. In fact, we emphatically support the principle of accountability and accountability agreements, and perhaps it's no surprise that we support this on the basis of accountability being a two-way street. This is repetitious, but we want you to know this information from the perspective of a medium-sized community hospital in a very high-growth area.

Let me tell you a bit about York Central. It is a community hospital. There are 425 beds. It's in the town of Richmond Hill. The population is about 150,000, but our catchment area takes us well beyond Richmond Hill into parts of Markham, Thornhill, the city of Vaughan, King township and parts of Aurora. The catchment area itself exceeds 350,000 people, and all the concomitant industrial and commercial developments with it. The projections for growth over the next five, 10 and 15 years are similar to what we've experienced in the last 20 years; that is, anywhere from 5% to 8% to 10% growth every year. We see that happening for the foreseeable future. In fact, literally half a mile from our front door we see population growth of another 50,000 to 60,000 in the city of Vaughan.

Why do I bring this up? Well, we think we understand growth, and we think we understand the kind of pressures that are placed on the health care system from growth alone. We're living with it every day. We think we also understand the need, and we agree that we have to find new ways to deliver health care. You may also ask how we maintain composure in the face of this kind of pressure. We stay the course. We do have a mission, we have values, we have a vision, and we embrace it.

We have circulated a package, and you'll see there are three pieces in the document. The first is our formal submission, and you'll see on the first page the hospital's mission, vision and values. We're committed to these. They're shared by everyone at the hospital, and that includes the front-line staff, the administration, the physicians and the hospital board; this is a made-in-York-Central document. This is not boilerplate; it's the underpinning of what we think is our accountability framework. The challenge, of course, in a high-growth

environment is to maintain that mission, the vision and the values.

While you have the package open, I'll point out to you the second document—the documents are divided by blue pages. There's a piece called Bill 8 Background Analysis. This is something we'll be discussing tomorrow night at our board meeting, and will form the basis of our discussion and a subsequent formal response to the standing committee before the deadline.

The third document is an article, "Redefining Accountability in the Healthcare Sector." You'll see it was authored by Bruce Harber and Ted Ball. I think if you have the opportunity to read it, you'll find it, like I did, a very insightful essay on a new approach to accountability.

Also, to take you back to the background analysis, if you look at page 2, you can see in the table a suggestion of where we are today and where we'll be in the future if Bill 8 is implemented without amendment.

I think the unfortunate impact of Bill 8 could be that it could actually move us away from local accountability and away from the best practices and systems designs that are presently espoused by practitioners in that business.

Let me repeat: There's no question in our view that the health care system needs some fundamental change. You'll see on page 1 of this backgrounder, if you just flip back one page, some challenges that all of us are facing: fragmented services, decline in patient and staff satisfaction, serious quality-of-care issues, out-of-control spending, politicization of resource allocations. We believe this is where we need to collectively apply some urgent attention. Without being too dramatic, this is a direct assault on patient care and public interest.

If I can highlight some of the materials in our first document, we welcome and embrace the opportunity to build on the long-standing tradition of accountability, efficiency and innovation. York Central and other hospital organizations in this province have been participating for some time in a balanced-scorecard approach, which is a joint initiative of the OHA and the Ministry of Health and Long-Term Care.

At York Central we have had a tradition of community stewardship and accountability through our board of directors since 1961—in fact, that is before the hospital even existed—and similarly since 1961 with the volunteer association, and also since 1977 with a foundation board of directors who raised incredible sums of money from our community for our health care service. In fact, that organization, the foundation, has raised over \$29 million in the last couple of years toward our major expansion and redevelopment project.

We do have some concerns with the Bill 8 provisions. We have generally three themes where we have concerns. One is that the hospital boards need to act in a governance role and not in an advisory capacity. Second, the expectation of boards is that they are independent. That's an essential part of the board's ability to fulfil its mandate of representing a community. Third, as I've said before, accountability needs to be a two-way proposition.

The minister has suggested that the accountability sections of the bill would result in some benefits to the health care system: clear performance targets, greater transparency and accountability, and greater collaboration and sharing of information. Yes, we think that's the intent, but we think there's a disconnect there between the intention and what is actually going to be delivered.

If I can move to our recommended amendments to Bill 8, there are five of them: One is that the hospital accountability agreements need to reflect best practices. There are perspectives that need to be included. That is more than the financing but is also the customer, the process, and the aspect of learning and growth. Accountability agreements should be designed to facilitate problem-solving. The assumption in some other jurisdictions where these agreements are in place is that there is a partnership between government and the service-delivery organizations. We believe that these agreements should be signed off only by the board chair, as the lead of the governors, and the Deputy Minister of Health, as the lead of the ministry.

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Second, we think that the services should be driven by a vision and a mission. As I've mentioned before, our hospital and, I'm sure, all others have that kind of mission and set of values. Accountability agreements should be based on those missions and visions as set out by the board of trustees. The bill, the way it is written, clearly has the potential to put the ministry in the role of system manager instead of system funder, which we fear would facilitate a great deal of control and micro-management, potentially, through rules and regulations.

Third, local boards should have performance agreements with their CEO. This reflects the high-level accountability agreement the board would sign with the ministry, and in particular the outcomes that are required by the hospital organization.

Fourth, an appeal mechanism should be included in the bill so that, where the board is not satisfied that their case is being heard or understood by the ministry, there is an opportunity to take those concerns to the next level.

Fifth, Bill 8 must specifically include a reference to the minister's obligation to act in the public interest. As it is currently written, we think Bill 8 could enable the minister to issue compliance directives without necessarily considering the public interest. If not amended, this bill could undermine public confidence in the goodwill and responsiveness of government and the health system.

From our experience, communities in the past have taken ownership of their hospitals. The board of trustees is accountable to both the community and the province as the principle funding source. In governing the hospital, the board reflects the particular needs of the community. Without the ability to govern, as opposed to advise, trustees—volunteers—may well question their relevance in the system. Similarly, foundations and volunteer association boards, who raise incredible sums of money in their communities and have direct contacts back to their communities, may question their ability to continue

raising funds, knowing that the ministry or the minister can, at any time, change accountability expectations and services at the hospital.

Mr Minister, this is not a criticism of previous governments, but an observation that one of the refreshing aspects of a change in government is a renewed interest in getting on with the job at hand, being more collegial, more mutually respectful. We encourage the minister and his staff to follow the lead of our Premier and work to continue this collaboration and mutual respect.

I think you've been given this before, but I do find some comfort in an excerpt from the speech from the throne in November: "Your new government understands it can only hold others to a higher standard if it subjects itself to the same standard." I think that is heartening. The will is there. Certainly we want to be a participant in improving this bill.

Despite all of this whining, we are grateful for the opportunity to participate in this initiative. We are grateful that the government is trying to do something about health care delivery. While we do take issue with parts of Bill 8, we are heartened by the efforts to date.

One last item: We do, of course, support all the recommendations and comments from the OHA. Those are my remarks.

The Chair: That's wonderful. Thank you, Mr Kirk. You've left about a minute for each of the parties to ask you one brief question.

Ms Martel: Thank you for being here today. Let me ask, if the bill with amendments still says that the minister can issue compliance directives, or orders, will that satisfy your concerns?

Mr Kirk: Sorry, I don't understand.

Ms Martel: The minister gave us some indication that he's going to be changing particularly the accountability agreements, so that they'll be negotiated, but in the framework that we've seen for changes it still says that the minister has to consider some representation etc before issuing compliance directives or orders. So if the minister still has that capacity to do that unilaterally, will your concerns as a board, particularly a voluntary board, be resolved, be addressed?

Mr Kirk: In fairness, I have to say changes on the fly are difficult to absorb and digest, to really come up with a reasoned response. I think it was Ms Witmer who suggested the other day that maybe this ought to have been a white paper so that there could have been more discussion and more dialogue. I share that view. It seems encouraging; the minister is prepared to make change. But I feel we all have to take a pause and consider these together and make sure that one proposal is not affecting another. I'm generally encouraged that the government is prepared to review this and make changes.

Ms Smith: Thank you, sir. I appreciate your presentation today, and the background information that you've provided is very helpful. You are aware that negotiations have been ongoing with the OHA for the past few months with respect to changes to this legislation, are you not?

Mr Kirk: Yes, I am.

Ms Smith: So you wouldn't actually suggest that the proposed amendments that we're talking about have been created on the fly, would you?

Mr Kirk: It has that appearance when we see it being presented through the press.

Ms Smith: But you do acknowledge that discussions have been ongoing for the past few months.

Mr Kirk: Oh, yes.

Ms Smith: And you're aware that the proposed amendments include the fact that the accountability agreements will be between the boards and the ministry, not the CEOs and the ministry.

Mr Kirk: Yes, I am. We don't know the details of those agreements, but—

Ms Smith: But you know that's the intention of the amendment.

Mr Kirk: Yes.

Ms Smith: And then the expectation would be, as you propose in your changes, that a performance agreement would be entered into between a CEO and the hospital board itself.

Mr Kirk: That's right.

Ms Smith: I take it you don't have any real concerns about accountability agreements in general between hospital boards and the Ministry of Health?

Mr Kirk: Not at all. In fact, Mr Harber's predecessor had a balanced-scorecard agreement with the board, and we are working on one with Mr Harber. It is a two-way proposition. We have expectations of the CEO to deliver, and similarly the CEO has expectations and commitments from the board to deliver so that the job can be done. If either party doesn't deliver, then the expectations change.

Ms Smith: Right. Given the proposed structure in the amendments, do you think that in any way jeopardizes your foundations or volunteer associations?

Mr Kirk: With the amendments?

Ms Smith: Yes.

Mr Kirk: As I say, I'd have to think about it. I don't think it does, no.

Mrs Witmer: Thank you very much for your presentation. Despite the last question about, "Would this jeopardize your board or your foundation?" there was the suggestion made yesterday by one of the presenters, I think Mr Watts, who said, "Perhaps this is a Trojan horse," and something to the effect that perhaps at the end of the day this is an attempt to change the governance structures and give the power to the minister and no longer the voluntary boards.

Until I see the amendments, I have to tell you, I am not reassured that this bill is not going to take away some of the power that the boards presently have. At the end of the day they may well become simply advisory boards. I don't know if you have any comment, but I am concerned.

Mr Kirk: As I said in my formal remarks, I appreciate the intent that the minister has explained. We're concerned that the document is not going to deliver on the

intent. Not only do we have a concern about accountability, but similarly clarity, to use the word, and everyone's looking for that. The more the government can incorporate into the bill, the better it is for everyone to understand.

Mrs Witmer: Thank you very much.

Again, Mr Chair, I would encourage the government to come forward as quickly as possible with actual amendments in order that we can give some reassurance to those who have been making representation to us.

The Chair: Thank you, Mr Kirk and Mr Harber, for coming forward today. We do appreciate it.

1240

SMITHSONIAN GROUP INC

The Chair: Our final group before the afternoon recess is the Smithsonian Group, Alan Smithson, the president. Have a seat and make yourself comfortable. You've got 20 minutes, the same as everybody else has here today, and you can use that any way you see fit. Any time remaining at the end of the presentation will be split amongst the three parties.

Mr Alan Smithson: Good afternoon to each and every one of you. My name is Alan Smithson. It's my privilege to serve as the president and CEO of Smithsonian Group Inc and represent the Canadian Pre-Paid Medical Plan on behalf of our clients, the physicians and patients of Ontario. I'm grateful for this opportunity to share some of our concerns regarding Bill 8, specifically section 16, the section on block fees.

I'm just going to branch away from my formal speech for one second because I realize that the OMA presented, I believe this morning, some information on block fees, as well as the Coalition of Family Physicians of Ontario, so I will just acknowledge that.

Before I get into this, I would like to tell you about Smithsonian Group and the Canadian Pre-Paid Medical Plan. Founded in 2003, Smithsonian Group Inc has created a service that provides a standardization of sorts to the uninsured side of medical care in Canada. Until now, physicians were given guidelines as to what they can and cannot charge for services that fall outside of the provincial formularies. Although the College of Physicians and Surgeons of Ontario does a great job ensuring proper ethical guidelines are in place, most physicians, in our experience, do not use these guidelines to create a fair and unbiased approach to billing patients for uninsured services. Many physicians simply lack written procedures and protocols to manage these extra services. This leads some physicians to reduce and eliminate many services provided to patients because there is no system in place to be compensated for such. It is important to note that the CPSO, or the college, has kept a very close eye on block fees, and thus far both patients and physicians are happy with the results.

With the shortage of primary care physicians in Ontario, it is important that three things happen: (1) that we keep the physicians we currently have, (2) that we

create a reason for graduating physicians to choose the specialty of comprehensive family practice over other specialties and (3) that we maximize the efficiency of the physicians and their practices.

All of these objectives must be done while appealing to the patients that the system serves. We feel that through the practice of block fees or annual fee programs physicians are better able to maintain a high level of service while being compensated for such. Patients also benefit from this system because it ensures that the services they require will still be provided and allows them to budget for a once-per-year fee for any service that may be levied in their doctor's office. Block fees allow everyone involved to benefit, including the provincial insurance program.

This is our formal submission. Under section 16 of the first reading of Bill 8, November 27, 2003, the following rules have been tabled. I'm going to read them out for the benefit of the viewers.

"16(1) Except as provided for in the regulations, no person or entity shall charge a block or annual fee.

"(2) A physician, practitioner or hospital shall not refuse to render an insured service to an insured person or refuse to continue rendering insured services to an insured person for any reason relating to an insured person's choice not to pay a block or annual fee.

"(3) For the purposes of this section, the Lieutenant Governor in Council may make regulations governing block or annual fees, including the circumstances under which they may be charged and the information that must be provided to the person who is charged, but may not regulate the amount of such a fee."

Ladies and gentlemen, point three is the reason I'm standing before you today. My clients, both physicians and patients, feel that bestowing power to regulate the rules under which physicians practise block fees to the Lieutenant Governor in Council is unnecessary and unwarranted. Currently, OHIP compensates physicians for approximately 98% of all services provided to Ontario patients. The remaining 2% fall under the category of uninsured services. Examples of these services include sick and back-to-work notes, insurance and third-party form completion, cosmetic procedures and third-party physical examinations. All of these services have been deemed medically unnecessary.

Physicians may charge their patients for these services through two means: (1) they can charge for each service individually or (2) they can charge an annual or block fee.

Because OHIP does not reimburse physicians for these services, neither the Lieutenant Governor in Council nor any elected official should have the right to dictate how physicians collect payment for these services. It is the opinion of Smithsonian Group Inc, the Ontario Medical Association, the Coalition of Family Physicians of Ontario and our clients—both physicians and patients—that the system of regulating block fees shall remain within the power of the College of Physicians and Surgeons of Ontario and not with the Lieutenant Governor in Council.

Until now, the college has been the self-regulating body for the conduct of physicians and surgeons in Ontario with regard to matters of financial, ethical, legal and medical practices. History shows us that physicians have adhered to the codes conferred upon them from the college, with very few exceptions. This system has been successful thus far. What Bill 8 is proposing is to take the responsibility away from the physicians and give it to individuals who may not be as adept at making medically related decisions.

Subsection 16(2) of Bill 8 suggests that physicians may not give preferential treatment to one patient over another on the basis of the block fee. I believe all of you would agree with this: This cannot happen. In its current form of governing block fees, this problem is dealt with swiftly and effectively by the college. It would seem illogical to create a department in government to try to deal with patient and physician complaints and issues surrounding block fees when the college is doing an effective job now.

In summary, Smithsonian Group Inc, the Ontario Medical Association, the Coalition of Family Physicians of Ontario, Ontario physicians and patients whom we have contacted feel that the proposed legislation of Bill 8, section 16, is unnecessary, and that the current method of governing block or annual fees requires no change. By passing Bill 8 in its current form, it is felt that you may undermine the authority of the College of Physicians and Surgeons of Ontario and the relationship it has with the patients of Ontario.

This is the reason it was important for me to appear before you today to express the opinions of all our clients. I trust that an amendment to Bill 8 will reflect the best interests of all Ontario residents and the health care providers who service them. Thank you.

The Chair: Thank you, Mr Smithson. You've left each party just under five minutes each for questions, starting with Ms Smith.

Ms Smith: Thanks for your presentation today. I had a number of questions about exactly your role in the block fee structure. Approximately how many physicians do you have as clients?

Mr Smithson: We have 10 physicians right now.

Ms Smith: Approximately how many patient clients would you have?

Mr Smithson: It's about 10,000 patients that we service.

Ms Smith: OK. You talk about the fact that the physicians are governed by the College of Physicians and Surgeons of Ontario. I just wonder where you fit into that scheme. If the physician is responding directly to the college if there's a problem, where does your company fit in?

Mr Smithson: What we do is try to standardize each physician. I don't know if any of you have been to your physician recently to get uninsured services, but the rates for things are not carved in stone. There are no regulations of the rates that physicians can charge. The OMA does give guidelines, and they have a section that they

hand out to the physicians based on what their recommended prices are. We do follow the OMA guidelines, thus standardizing what every physician charges.

I was recently in an office with three physicians. One of them was charging \$40 for a driver's medical; the other was charging \$140 in the same office. That kind of discrepancy leads Ontario patients to be wary of why they're being charged for these services and what they could be charged in the future. We act to standardize that.

To answer your question, we follow the college's guidelines to a T. We try to follow the most ethical way to do this. I have read reports of physicians saying that they're going to exclude a patient from the practice based on their decision not to go with the block fee. We find that this practice needs to be punished or dealt with by the college in maybe a little bit more effective manner. These complaints do go before the college's board. If we hear of physicians who are doing such, we make recommendations to them that they adhere to this. There are a number of physicians we've met with who aren't adhering to the college's guidelines, which we give them a copy of. They may just be unaware of such. The college's guidelines are under review right now.

Ms Smith: Right, but the agreement that you have with the patient is an agreement between yourself and the patient, is that correct?

Mr Smithson: It's not. It's actually an agreement between them and their physician. What we do is organize and standardize it for the physician. We send it out on behalf of the physician, but the agreement is with the physician and the patient.

Ms Smith: Who collects the block fee in that case?

Mr Smithson: We do. We have two options that the physician can do. We can do the block fee for them, in which case we collect the money for them. We deal with all the processing and payments so that they can focus on the practice at hand.

Ms Smith: How are you paid in that system?

Mr Smithson: We're paid a percentage of the block fee, and we're paid up front.

Ms Smith: "Paid up front" meaning—

Mr Smithson: The physicians pay us a certain amount up front to implement their block fee and organize their uninsured service side of things.

Ms Smith: What would an average block fee be for a family of four?

Mr Smithson: A family of four? Two hundred and fifty dollars.

Ms Smith: I take it, in your structure, they pay the \$250 annually. It doesn't matter how many services they use in that year. If they use no services, there is no reimbursement of that \$250.

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Mr Smithson: Absolutely correct. That's the whole idea of a block fee, that you're paying for services up front even if you don't use them. It's similar to an insurance program, only it's provided to you from your physician.

Ms Smith: Have you had any discussions with the College of Physicians and Surgeons of Ontario? Because if the agreement is between the physician and the patient but you're doing the collecting and doing the drafting, I would suspect that somehow in there the college would want to get involved if there's a problem.

Mr Smithson: You would think so. We have been in touch with the college and we have run all of our materials by them. The college acts on a complaint basis, so they will not give you information regarding what you've already done until there is a formal complaint, which we have not had yet.

Ms Smith: You did say at one point, "Patients also benefit from this system because it ensures that the services they require will still be provided," That would seem to somehow indicate to me that you think the services they are being provided may not be in the future if these kinds of block fee systems are not in place. On what basis do you make that statement?

Mr Smithson: How many of your family physicians here provide—and I'm going to pose this question to all of you—telephone prescription repeats or fax repeats by phone?

Ms Wynne: Mine does.

Mr Smithson: Yours does? There are a number of physicians who, in place of doing that, have said, "No, we're not going to provide these services any more. We're not going to take your telephone calls. We're not going to take messages. We're not going to return your calls. We're not going to do sick notes or passports." So by them not being compensated for such, they've said, "Instead of billing the patients, we'd rather just not provide the service." And that's what we're seeing all over Ontario.

Mr Arnott: Thank you very much, Mr Smithson. I found your presentation very interesting. I wasn't aware that there was a company like yours in existence providing this service for doctors. I think it's probably something that most of the committee members aren't aware of as well, so I think your presentation here today was very helpful. I would agree with you completely in the sense of your statement that we need to keep the physicians we have. Physician retention has to be a high priority. We need to create a reason for graduating doctors to choose the specialty of comprehensive family practice. Certainly that's something that I would agree with and we need to maximize the efficiencies of physicians in their practices.

I had a question which you answered in your presentation. I was wondering how much of the overall billings of doctors was covered by OHIP.

Mr Smithson: It is less than 2%.

Mr Arnott: About 2% is the uninsured services they provide. So that's an interesting juxtaposition of facts.

Mr Smithson: The other part of what we do is we help to educate the Ontario public—I would say the Ontario public, but the Canadian public in general—as to what is and what is not covered. Every patient we represent, that we send information to, gets a comprehensive

patient information package which explains to them each service, why they're being charged for such and the prices for such according to the OMA guidelines.

Mr Arnott: You've said quite clearly that the College of Physicians and Surgeons is, in your opinion, doing quite a good job of regulating block fees.

Mr Smithson: For the most part.

Mr Arnott: Why do you suppose the government feels that it's necessary to take action in this respect with Bill 8?

Mr Smithson: I refer back to—give me two seconds here. The Ontario Health Coalition is opposed to block fee charges, and their only research has been articles that they've read in the *Globe and Mail*. That is probably why this has been tabled, because our media do have a lot to do with the policies we create.

Having said that, there are thousands of physicians in Ontario. Out of the thousands of family care physicians, two of them not abiding by the college's regulations do not represent a reason to strike down or to amend a current issue that's there. The reason the college is involved is that they are the regulating body behind the physicians. Whether it be services that are provided under the OHIP umbrella or outside of it, their conduct is representative from the college.

Mr Arnott: The Minister of Health, at the outset of these hearings, announced a statement of intent in terms of bringing forward amendments. Do any of those amendments—

Mr Smithson: I do have those amendments. Section 16 is not addressed in those amendments. What we would like to see ultimately is the section on block fees left exactly as it is, with the only change being: "the College of Physicians and Surgeons may make regulations governing," instead of, "the Lieutenant Governor in Council may make regulations governing," That's the only change we would make. Leave the structure of block fees within the college.

Ms Martel: Thank you for being here today. It wasn't only the Ontario Health Coalition who told us they had a problem with block fees. On Monday we had a presentation from the Medical Reform Group, who also represent primarily family physicians in Ontario, who in no uncertain terms said we should get rid of block fees.

Mr Smithson: What was their rationale, if you don't mind my asking?

Ms Martel: They felt that in a time of underservice, of a great lack of physicians in Ontario, most patients would feel that if they didn't pay the block fee, they weren't going to get any medical service; and secondly, that there is a discrepancy in what is being charged—you pointed out that, in the same practice, you went from a charge of \$40 to \$140 for the same service. There was one other that was a very good rationale in terms of why they, primarily as a group of family physicians also operating in Ontario, thought this should be done away with.

In that respect, I look at your own presentation, and here's one of your lines: "Although the College of Physicians and Surgeons of Ontario does a great job at

ensuring proper, ethical guidelines are in place, most physicians do not use these guidelines to create a fair and unbiased approach to billing patients for uninsured services." I'm not sure what you meant by that. I think I also heard you say the college needs to deal with these concerns in a more appropriate manner. So after I listen to you, I have some concerns about what seems to be a contradiction in your own presentation to us about physicians essentially having much different approaches to block fees and your concerns about that, and concerns about the college not responding in an appropriate manner to deal with that.

Mr Smithson: You put me on the spot here.

Ms Martel: I didn't mean to.

Mr Smithson: The college does have guidelines there. They have the means to enforce them, and they do enforce them to the best of their ability. Having said that, there are a number of instances I can point out where physicians are simply not following them, maybe because they don't know about them, maybe because there are not enough people watching it. If the Lieutenant Governor in Council is going to take control over how block fees are run, I think more specific rules and regulations as to what the Lieutenant Governor in Council will do with that need to be tabled. Either leave it in the hands of the college or at least make it clear. It says here: "the Lieutenant Governor in Council may make regulations governing block fees, including the circumstances under which they may be charged and the information that must be provided." That leaves the door open for them to do pretty much anything.

Ms Martel: When you say you have examples of physicians not following the guidelines, what do you mean? Do you mean they're charging over what the guidelines say?

Mr Smithson: There are no guidelines with regard to prices. Bill 8 does not discuss the price guidelines. It says right there: "may not regulate the amount of such a fee." So physicians can charge whatever they want for whatever service falls outside OHIP.

Ms Martel: OK. So what does the College of Physicians and Surgeons and the OMA give, then? We heard from the OMA this morning that they have guidelines too. What does that mean? Are they giving physicians a suggested price list for these services? Is that what it is?

Mr Smithson: The college, no, but the OMA does have a suggested price list for services outside OHIP, and physicians who are running block fees sometimes follow it and sometimes don't.

Ms Martel: In your experience, are they above?

Mr Smithson: No, usually below. It depends on the physician's office.

Ms Martel: How do you explain a gap of \$40 to \$140 in the same office for the same service?

Mr Smithson: I cannot explain that.

I don't want to say too much with regard to what the physicians are doing, but I know that some physicians are billing the government for physicals that are third-party or outside OHIP. So if somebody comes in for a third-

party physical, rather than charge the patient, which they're not comfortable with, they bill it to OHIP and then charge the patient the difference for the form. That does contravene the OHIP guidelines. So those rules are all over the board; what the physicians are doing is all over the board.

Ms Martel: If I can just go back to your statement, when you made reference to the College of Physicians and Surgeons and talked about ethical guidelines, what kind of guidelines were you talking about? My assumption was that you were talking about pricing guidelines, but what is that?

Mr Smithson: The guidelines are actually in the OMA's report on page 31. It does have an example of their guidelines and their policy in place there. What it states is: "the patient must be advised of the amount of the ... charges," and they don't give an example of an amount. The patient must be given the option to pay individually or pay the block fee; it's not a comprehensive" You have to pay or leave." "The decision as to whether or not to elect this form of payment must be the patient's" and not the physician's, and the patient must be given a copy of the block fee rules, so the patient knows. These are all done through our program, but not necessarily done at the individual level of the physician.

The Chair: Thank you, Mr Smithson.

We're recessed until 2 o'clock.

Before we go, for those members of the committee who are going to be joining us in Niagara Falls tomorrow, the bus will leave from the south doors at 7:45 am, and we'll have a brief stop in Oakville.

The committee recessed from 1302 to 1403.

MARC SIMBROW

The Chair: We can call the committee back to order again. It's a few minutes after 2. Our next delegation is Mr Mark Simbrow. Would you like to come forward, sir, and make yourself comfortable, or as comfortable as you can be with that thing. You've got 20 minutes, and you can use that time any way you see fit. Any time left over after the presentation will be split among the three parties to ask you any questions they may have. The time is 2:04.

Mr Marc Simbrow: Thank you kindly. I would like to thank you for giving me the chance to speak to the standing committee on justice and social policy. It is an honour to participate in open government to express my views on Bill 8.

I agree that all Ontarians should be treated equally and that we must have equal access to health care. I have seen the nurses in Ontario under the last government. By cutting back in health care, both the nurses and doctors were hurting. Nurses play a very important part in health care. They work so hard and are very dedicated. Bill 8 is a positive step in health care. I have seen the nurses today. They are positive and happy, and believe that change is coming in the system for the betterment of this province. Honourable members, nurses are at the first forefront of health care.

Living in Toronto, we have good-quality health care. However, when you are in northern Ontario, like Moose Factory or other parts of this great province of ours, we must also encourage that there be nurse practitioners to assist doctors in remote areas. Midwives are also very important in the assistance of patients, and this acts as another access.

For patients in chronic care, we must assist families in every way possible.

For the future of health care, chiropractors should be covered by OHIP. Chiropractic care has helped with fewer hospitalizations and a highly significant reduction in chronic problems, as well as in levels and duration of disability. For the future of health care, not only should podiatrists, osteopaths and physiotherapists be included in OHIP but also ambulance drivers, with the new title of paramedics. We must seek alternatives to include them.

Access to publicly funded health care is a fundamental part of the Canadian social fabric. Ontario must not have a two-tier health care system. We need a health care system which is fair and just for every Ontarian.

Once again I would like to state that nurses are starting to believe in Ontario, and they are providing a vital service. Where would we be without them? We should hire more nurses and doctors, as well as nurse practitioners, all over the province of Ontario and not only in remote areas. By hiring more nurses, doctors and nurse practitioners, we will cut the wait in emergency rooms.

Also, for optometrists the system has not changed since 1990. If you are a senior citizen, you may have an appointment every year, while if you are aged zero to 60, you must wait every two years. This part of the bill should be amended so that every Ontarian is able to see their optometrist every year.

Let's look at naturopaths and let's look at other alternatives that will help to bring them into OHIP. Let Ontario be a shining example for the rest of Canada. Thank you kindly.

The Chair: You have used only about six minutes, which actually leaves us between four and five minutes per party to ask you some questions, if you don't mind answering them.

Mr Simbrow: I'm going to have some difficulties in pouring water.

The Chair: OK, maybe we can have someone help you. We're a full-service committee here. Let's start with Mr Arnott.

Mr Arnott: Thank you very much for your presentation this afternoon. When we do public hearings on bills, as a committee we certainly appreciate the input we receive. Quite often, the committee lineup is mostly interest groups and organizations that have a particular perspective they wish to offer, but I think it's always helpful when the average citizen takes advantage of the opportunity to come in and talk to a committee like this as well. Certainly you've articulated a lot of good suggestions for the government of Ontario, and I know it's appreciated by all of us, so thank you very much for coming today.

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Ms Martel: Thank you for coming today to make the presentation. You raise some concerns we have heard before, particularly with respect to regulated health professionals whose fees are not fully covered by OHIP, for example physiotherapists and chiropractors. Certainly the concern has been raised with the committee by representatives from those groups, but also by others who use their services, that it can be cost-prohibitive to use these health care professionals, depending on what the fee is in addition to the OHIP billing. If you're going to a chiropractor, for example, and you're paying \$15 or \$20 out of your own pocket, for many people that is cost-prohibitive.

That's a difficult issue in that if you go to full funding of those services through OHIP, how much would that cost the system? I suspect it would cost a fair bit, but I suspect that on the other end there would be some cost savings for people using those health care professionals who then might not have to have surgery or more costly intervention in the long run.

So you're concerned about having these services covered, I think primarily a concern due to cost, and how much it costs people to pay for that is a very valid concern. The committee will certainly consider if that's something that can possibly be done.

Mr Simbrow: Ms Martel, I'm sure you have the latest study of the Ontario Magna report.

Ms Martel: No, I don't.

Mr Simbrow: You don't? That's where this comes out for chiropractic care—very important.

Ms Martel: Thank you.

The Chair: Ms Smith isn't here. Ms Wynne?

Ms Wynne: Mr Simbrow, thank you very much for coming down today, and thank you for acknowledging the open process we're engaged in. Indeed, this bill is coming out to committee after first reading, which allows input at a very early stage. We appreciate your taking part in that, and there will be other opportunities for consultation.

I wanted to pick up on your comment about nurses and the need for more nurses in the system. I don't know if you were able to hear or get a copy of Minister Smitherman's comments yesterday about money that is going to flow into the health care system. Did you hear his speech?

Mr Simbrow: As a matter of fact, I did, and I'm very pleased by the honourable member.

Ms Wynne: Good. So you're supportive of this direction, where we would say, "This is our target. We want the money spent in this way, and we're going to hold the institutions accountable." You're supportive of that?

Mr Simbrow: For sure. Yesterday, when I was in the hospital, I could even hear the nurses, and they were really talking positively.

Ms Wynne: That is very good feedback. Thank you.

Mr Simbrow: Where before the nurses were saying, "I want to leave Ontario," today they're starting to really

feel positive. They feel they are in the system and that change is coming, and they believe. That's very important.

Ms Wynne: So they heard our message loud and clear that we were supportive of them.

Mr Simbrow: Yes, and they believe in it.

Ms Wynne: That's great. Thank you for that feedback, and thank you for coming today.

The Chair: Thank you, Mr Simbrow. Are there any further questions from the government side? There being none, I'd like to thank you for coming.

Mr Simbrow: Thank you kindly, Mr Chairman.

The Chair: No problem. It's still your 20 minutes. You can sit and drink your water if you'd like to.

Mr Simbrow: No, that'll be fine. Might I tell you, the hockey game was good. I got the guy, but I don't know if I'm good enough for the Toronto Maple Leafs.

The Chair: OK. Thank you.

SCARBOROUGH HOSPITAL

The Chair: If our next delegation could start to prepare to come forward, we're going to hear from Scarborough Hospital. It's Terry Brazill, the board chair, and Gary Johnson. Please be seated. Make yourself comfortable. You've got 20 minutes to use as you see fit. At the end of your presentation, if there's any time left over, we'll try and split it proportionally among the three parties to ask you any questions. I've got 2:15, and you've got the floor.

Mr Terry Brazill: Good afternoon, Mr Chair and members of the committee. My name is Terry Brazill. I'm the chair of the board of directors of the Scarborough Hospital. To my right is Gary Johnson. Gary's the vice-chair of the board.

We're pleased to have this opportunity to appear before the standing committee on justice and social policy as it considers Bill 8, the Commitment to the Future of Medicare Act.

For those members of the committee who are not familiar with the Scarborough Hospital, let me tell you a little bit about us. The Scarborough Hospital is one of the largest and busiest community hospitals in Ontario. The hospital was created in 1999 and continues the legacy of care of its two founding hospitals, Scarborough General Hospital and the Salvation Army Scarborough Grace Hospital. Today, the hospital serves the very real and evolving health and wellness needs of a very large, diverse and high-need community. The population in the hospital's primary catchment area, Scarborough and the southern part of York region, is close to one million people. It continues to grow at a significant rate. Our mission is to provide excellent patient care, promote health and improve the quality of life. We deliver a broad range of emergency, ambulatory and inpatient care, along with services that reach out to our community. We foster research and education that enhances health care delivery. At the Scarborough Hospital, care is provided to more than 300,000 people every year. Our emergency

department is the busiest in the greater Toronto area, serving over 101,000 patients. If one of you were to get sick today, there's a one-in-three chance that you'd end up at our hospital.

We applaud the government's commitment to seek innovative solutions to delivering cost-effective, accessible and high-quality health care, and we firmly believe in the need to protect essential health care services, in particular by making that system sustainable financially. We recognize the importance that the people of Ontario and the members of our community place on accessible health care. We support the need to preserve the principle that Ontarians should have access to medically necessary health care services based on need, not on their ability to pay.

The minister has proposed, and we support, a number of amendments to Bill 8. We remain concerned, however, about the applicability of the accountability agreements contemplated in the bill, which we believe could undermine the government's intent with respect to this legislation.

In this regard, we echo and support the positions that have been put forward to the ministry and this committee by the Ontario Hospital Association. Bill 8 must support the role of independent voluntary boards and the voluntary governance structure at hospitals. This is the cornerstone of the public hospital system in Ontario. We agree and we accept our accountability for the prudent, efficient and transparent management of public funds. We take this seriously and we in Scarborough believe we do it well.

The minister has publicly acknowledged that boards have a tremendous responsibility and are entrusted with ensuring high-quality care for the people they serve. We wish to confirm our support for the proposed amendment to subsection 21(2), which would maintain the independence of the governance structure by requiring accountability agreements between the ministry and the hospital. However, accountability agreements must be custom-made and tailored to the unique needs of each hospital and the communities they serve. A cookie-cutter approach for the implementation of accountability agreements will simply not work. Not only would this not achieve enhanced accountability in the system, it could effectively silence the voice of the community in determining service outcomes and ensuring quality care. This will have an adverse impact on health services and patient care in our community and other communities across the province. Let me explain.

Our board of directors is comprised of dedicated, committed members of the community who volunteer thousands of hours annually to the hospital. We are the voice, the face, of the community we serve, a community that often struggles to be heard. A couple of examples will demonstrate how this works in practice.

First, our community has demonstrated tremendous support and gratitude for our work during SARS. We were there when we were needed most and at a time when many others were not. Our SARS experience high-

lighted the community's strong desire and need for local leaders to provide local decisions. Our board of directors played a critical role in providing support to management and in ensuring that the community's broader health care needs were not compromised.

Second, when our community told us they needed access to care for the uninsured, we listened. One of our physicians, Dr Paul Caulford, was recently recognized for establishing an urban outreach health clinic which provides access to care for people who don't have health insurance. Without our hospital, it is conceivable that these voices would not have been heard and access to these much-needed services would not have been possible.

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Our board members are passionate about ensuring that our hospital provides the best possible health care to our patients and their families. Just ask Gerry Phillips or Brad Duguid. Both Gerry and Brad have served with distinction on the board. In fact, Gerry was a past chair of the board. They are both well aware of the importance of being connected to the community.

Our community members live and make their living in Scarborough. We are in a position to know, understand and appreciate the needs of the community and the challenges and opportunities that our hospital faces. Our families and our neighbours utilize and depend on the services.

Board members not only reflect but represent the community that our hospital serves, a community that today comprises more than 25 ethnic groups and which the World Health Organization acknowledges as the most ethno-racially diverse community in the world. Our board also provides hospital management with leadership, support and guidance, drawing on members' individual and collective experience and multi-talented and multi-faceted skills.

Let me stress, our board is accountable, and we recognize and support the concept of accountability agreements. Practically, this could provide us with an opportunity to resolve the details of, and obtain the minister's approval for, our long-term master plan/master program that we have prepared and submitted to the ministry.

However, the bill should consider that if an agreement cannot be reached on an issue or series of issues between the ministry and the hospital, there must be a mechanism in place for dispute resolution, such as the appointment of an independent arbitrator.

We support the proposed amendments whereby the hospital CEO is no longer party to the accountability agreement. The CEO is accountable to the board for their performance and the board is responsible for the conditions of the CEO's employment through clearly outlined performance objectives and outcomes. Our board takes this role very seriously.

There is one final area that I want to touch on today. Later this year, we intend to publicly launch a capital campaign to support a much-needed emergency and critical care centre. We hope to raise substantial money

from the local community with the understanding that the hospital board performs a role with respect to a certain scope of health care decisions—decisions that are often based on the community needs and desires.

The accountability agreement should take into consideration the endowment funds available to a hospital through its foundation. The reality is that Scarborough Hospital is below the radar screen when large foundations or corporations are considering donations to various organizations. This places the hospital and the community at a disadvantage.

Let me conclude my remarks by saying the Scarborough Hospital has distinguished itself as a front-line champion of the evolving needs of Canada's new urban communities. We are committed to ensuring that the people of Ontario and our local community continue to have access to the health and wellness services they deserve. We urge this committee to support amendments that strengthen medicare in Ontario.

At this point, we would be prepared to respond to any questions. I want to thank you very much for your time and attention.

The Chair: Thank you, Mr Brazill. I appreciate it. You've used about 11 minutes, leaving us with nine minutes.

Ms Martel: Thank you for coming today. I'm going to focus on page 15 on point 35 and point 37. You said that if there can't be an agreement reached on an issue between the board and the minister, then there should "be a mechanism in place for dispute resolution, such as ... an independent arbitrator."

I wonder, then, if you understand what the minister has proposed in terms of the accountability agreements, which is that, at the end of the day, if there isn't an agreement, the minister has the power to issue compliance directives or orders unilaterally. That is the proposal that he has made to this committee as of last Thursday. That's quite a bit different than the appointment of an independent arbitrator to deal with a dispute in question and to deal with the resolution.

What does your board think of the premise that the minister still has, at the end of the day, the unilateral ability to issue a compliance directive or order?

Mr Brazill: The board represents the community, and the community needs to be heard. If we were to look at arbitrarily doing a cookie-cutter approach to this, very likely—I'll give you a real-life example in terms of SARS. If the ministry had been able to do what they wanted to do, likely the Scarborough Grace Hospital would not be open today. So very realistically, the community needs to be heard.

Ms Martel: So you're not in favour or you are in favour of a situation where the minister has the final say? That is exactly what we're looking at right now.

Mr Brazill: No, we're not in favour.

Ms Martel: The other point was, your CEO is accountable to the board, and the board is responsible for the conditions of the CEO's employment. The other thing we were given last week in this regard was a framework

for the amendments where CEO compensation clawback is still at the discretion of and in the hands of the minister. So again, your role as board members is completely undermined because the minister at the end of the day can still do compensation clawback or other remedies with respect to your employee, who is the CEO. What does your board think about a situation where clearly the CEO is still going to be responsible in some way, shape or form back to the minister?

Mr Brazill: Our position, as I think we've laid out, is that the board feels that it should be the one that's responsible. That's where the accountability should be. The CEO needs to be the board's employee. It is now, and that facility needs to remain in place.

Ms Smith: I'm actually not going to be making very many comments. I just wanted to thank you for your presentation. Mr Duguid is going to speak, but I also wanted to thank you for acknowledging the work that has been done on coming up with proposed amendments. You actually acknowledged that they're happening and being discussed, and it's a lovely change.

Mr Duguid: I want to thank you as well for taking the time to join us today. You're part of a board that has some of the largest challenges in our system, with probably the busiest emergency in the country, a hospital that was at the epicentre of the SARS crisis, and a hospital that was recently amalgamated. You've got some very large administrative challenges there, and the board, I think, is probably stronger and more vibrant than it ever has been.

I want to tell you that I wouldn't be supporting this approach, this legislation, if I thought for one second that this legislation was going to usurp in any way the powers of the board. At the same time—and I think you probably agree—the minister made a speech yesterday talking about the need to really focus on outcomes and on our priorities—reducing waiting times, access to care and making Ontarians healthier being the three priorities. There is no way we could shift the system to get to the outcomes we want to get to if we don't have some ability to ensure that there's accountability in the system. I don't mean accountability in terms of just value for dollar; I mean accountability in terms of getting all the stakeholders in the entire system to be playing from the same playbook in terms of moving forward with the reforms.

I just want to make it clear that we're not looking at getting into the day-to-day operations of the boards. What we are looking at doing is making sure that for those few boards—and I know Scarborough would not be one of them—that just simply refuse to play ball, that simply refuse to come onside in reaching the priorities we were elected to bring forward, we have a mechanism to ensure that we are able to pull them onside.

Mr Brazill: As you know, Brad, from working with us—Brad was on the board up to his election—we want to provide every service we possibly can to the community. There is no question in terms of the board's commitment to medicare and the people of our community. If we were able to see funding over a period of time,

where we understand what we have to deal with, instead of at the last minute so that we're running programs which we really don't know whether we can afford—that's been an ongoing process, as you're very much aware. I think the key is to hold the board accountable. You can pass legislation that says, "Don't run a deficit," and allow us to do our job.

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Mrs Witmer: Thank you very much for your presentation, Mr Brazill and Mr Johnson. You've expressed a concern here as it applies to the accountability agreement. We've heard the suggestion from some people within the hospital sector that what this is really going to do at the end of the day—it has the possibility of eliminating boards and the role of boards, the governance structure we have in place today. As you know, it's basically shifting power from the boards to the minister as he or she enters into accountability agreements which will not be negotiated and will give the minister the opportunity to issue directives. If no amendments are made, do you see this legislation reducing boards to simply having an advisory role, and if that were the case, what would happen to the people who presently serve on your board?

Mr Brazill: If I had given you this presentation yesterday, before we got the most recent thoughts on amendments, it would certainly be a lot different. As you're very aware, it would make the board ineffective. But I think the amendments that are being proposed at this point address most of those issues. Obviously we haven't seen them in specifics, so it's hard to comment on something vague, but I think we're going in the right direction. As long as we continue to realize the role of the board and not take away its accountability, make the board accountable, I don't think boards have any problem with that. I think we want to be. We're accountable to the community and we need to be accountable to the government as well.

Mrs Witmer: But you don't mind the fact that there is no accountability for the minister to the public or to the board? The way the accountability agreement reads right now, folks, it's a one-way street. Does that not concern you?

Mr Brazill: As it is today, but I'm confident that that will be addressed with the recent announcements on amendments.

Mrs Witmer: Then I would say you have more confidence than most of the boards that have come before us in the last two weeks. I hope you're right.

Mr Brazill: Maybe I'm a babe in the woods, but I feel we have to have confidence in the elected officials, and I really do feel you're going to do the right thing at the end of the day. That's why we're here. We would have some major concerns as it relates today, but I know you're going to do the right thing as far as the amendments.

Mrs Witmer: Well, you just keep saying it and maybe they will.

The Chair: Thank you, Mr Brazill, and thank you, Mr Johnson, for accompanying Mr Brazill today. We certainly appreciated your input.

**ONTARIO PUBLIC SERVICE
EMPLOYEES UNION**

The Chair: Our next delegation is from the Ontario Public Service Employees Union, represented today by Leah Casselman, the president, and Patty Rout, the vice-president, local 348, and chair of the OPSEU health professionals. Please make yourselves comfortable.

Ms Leah Casselman: Thank you, I will. This chair is kind of nice.

The Chair: The same as everybody else who has appeared before us today, you have 20 minutes. You can use that any way you see fit. If there is any time left at the end of the presentation, we'll split that proportionally among the three parties.

Ms Casselman: Excellent. As you've just heard, I'm Leah Casselman, president of the Ontario Public Service Employees Union. This is Patty Rout, who chairs our health council, representing six health care divisions within OPSEU. OPSEU is grateful for the opportunity to participate in this public consultation.

Almost one quarter of all OPSEU's 100,000 members work in health care. They work as paramedics and dispatchers in our provincial ambulance services; they are service, office and clerical workers; hospital professionals and nurses in public general and psychiatric hospitals; and they work in long-term-care facilities and in the community home care sector. They work in public health and in mental health. We pretty much cover the waterfront here. They see first hand what has happened to health care in our province over the past eight years.

OPSEU echoes the concerns of the Ontario Federation of Labour and the Ontario Health Coalition. Our remarks will focus on the areas of most concern to our members.

Bill 8, the Commitment to the Future of Medicare Act, has a lofty title, but we have grave concerns that this bill will not fulfill those objectives. As it stands, the bill does nothing to further the principles of the Canada Health Act. It does not prohibit the further erosion of the scope of medicare. It does not deal with the increasing problems of privatization, profit-taking and the two-tiering of uninsured services. Further, it opens the possibility of extra-billing and allows block fees for physicians. We are particularly concerned that the bill gives the minister sweeping powers to order restructuring of the health care system without any democratic control, input or checks and balances.

The bill's preamble recognizes that our system of publicly funded health care services reflects fundamental Canadian values and that its preservation is essential to the health of Ontarians. It confirms the enduring commitment to the five principles of medicare: administration, comprehensiveness, universality, portability and accessibility, as currently codified in the Canada Health Act. This commitment should be broadened to provide for significant new initiatives with respect to these principles, including the absolute and unequivocal prohibition of two-tier medicine, extra-billing and user fees. The bill should also commit to not only publicly funded

but also publicly administered and delivered health care services.

The government has indicated that this bill should strengthen and restore public confidence in the health care system. This confidence has been eroded over the last eight years, and no one knows that more than OPSEU members on the front line. Patty Rout will now describe further what front-line workers see for this bill.

Ms Patty Rout: I'm Patty Rout and I'm a lab technologist at Lakeridge Health, Oshawa. We have four hospitals and we have 21 work sites. I'd like to paint a picture for you of the problems in the health care system as my members and other health care workers in OPSEU's six divisions see them.

In long-term-care facilities, thanks to the previous government, we have no minimum standard of care. Staffing levels are among the lowest in Canada. Inspections are too infrequent and are announced to the companies beforehand. The majority of new nursing home beds have been handed to for-profit corporations. Resident user fees are up. The proportion of beds in long-term-care facilities held for those who can afford to pay a premium for a semi-private or private room has gone up to 60%, reducing the number of basic ward beds available. There is inadequate staffing in long-term-care facilities. This forces families to pay for their own caregivers, if they can afford to do so. Otherwise, residents go without even basic care as hours of care have been reduced while acuity has increased.

Home care: The privatized delivery of home care through the competitive bidding model has created tremendous instability. Six years after its inception, Ontario's home care system is rife with duplication, excess administration and profit-taking. This has had an impact on our workers as wages and working conditions are driven down. It has also harmed patient care. Not-for-profit organizations, such as VON, with long histories of providing quality care are being driven out of home care by this cutthroat competition. The second wave of divestments has fragmented services. It has caused instability and caused professionals to leave community care.

Precious health care dollars are being redirected out of patient care and into ballooning administrative costs, creating staff shortages and instability. Approximately \$42 million per year of public money goes to profit the owners and shareholders of private companies. Home-making and home support services have been virtually eliminated across the province, primarily affecting the frail elderly and disabled.

Tax dollars have been diverted from hospitals to finance tax cuts, leaving Ontario hospitals scrambling to provide essential medical service. Over the past eight years, the numbers of acute, critical and chronic care beds were cut by almost 9,000. The previous government closed 39 hospitals and cut 25,000 staff.

To finance rebuilding and redevelopment of our hospitals, the government's proposed solution is public-private partnership, despite promises made during the last election. The government argues that the William Osler

and Royal Ottawa hospitals are not public-private partnerships. However, the consensus is that the minor contractual changes announced in November 2003 do not substantively change the character of these P3 projects. There are also more P3 hospitals on the agenda in various stages of planning.

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The evidence that public-private partnership hospitals cost more is overwhelming. Following the same model as privatization in Britain, Ontario's P3 hospitals are already showing cost increases from initial projections. In Brampton, capital costs alone have increased from \$300 million to over \$350 million. In Ottawa, costs are up from an original cap at \$100 million, to over \$132 million. P3 deals are secretive. There is no public transparency on contracts. We do not know the extent of privatization; we are not told about timelines, commercial land deals and payments from hospital operating budgets.

For-profit operations in health care push dollars away from patient care to shareholders' pockets. Inevitably, either hospital services will cost more or services will be cut to keep shareholders happy. Both patients and the taxpayers suffer.

There is a severe shortage of health care professionals in hospitals. I'd like to say it's not just nurses; it's many health care professionals in this province. I can talk about that later. An older workforce is retiring. For hospitals and other health care providers, the ability to meet the needs of their patients depends on their ability to recruit and retain health care professionals.

Another staffing issue is the rate of part-time, casual and agency workers in our hospitals. This was illustrated very graphically during the SARS crisis last year. The expert panel on SARS said, "Existing rates of casual, part-time and agency employments are undermining efforts to ensure a stable and cohesive workplace."

We can't forget our shock last year when Health Minister Clement admitted he had no idea of the casualization of work in hospitals.

Laboratory services: The province's public health labs have been starved for resources, to the point that people working in key areas have been eliminated just when their work was most needed.

Lab restructuring is going on all across the province. The Ministry of Health seems intent upon increasing the role for the private sector in the provision of lab services. Private delivery of lab services has not contained costs. Indeed, new user fees have been introduced. Mobile unit pickup lab services that used to be provided at no charge are now subject to a user fee of \$15 per pickup.

Public hospital laboratories operate at a disadvantage. Private laboratories bill OHIP on a fee-for-service basis, while hospital laboratories are funded out of hospitals' block funding. For-profit labs have taken the higher-volume and lower-cost tests while hospital labs must deal with more complicated, specialized, non-routine and less profitable tests.

The planning for laboratory restructuring involves the Ministry of Health, hospitals, community—including

private—laboratories and physicians. Human resource planning is already underway, but OPSEU, which represents the vast majority of lab technologists and technicians in this province, has not had any involvement in this planning process—and it's not from lack of asking.

Private MRI and CT clinics: Private stand-alone clinics such as MRIs and CTs operate outside the public medicare system and drain money from the hospitals through third-party billings—WSIB and third-party insurance. This deprives our hospitals of revenue. Private clinics also poach our skilled staff from the public system.

A job in a private clinic can be very attractive to overworked, underpaid, stressed-out hospital health care professionals. This further undermines our public health care system. Private clinics also enable queue-jumping for so-called medically unnecessary services.

Ambulance: Downloading and other upheavals in Ontario's ambulance services have created severe imbalances in the system that must be addressed. The province has downloaded these services without proper funding. Some municipalities, like the city of London, have torpedoed fair deals for paramedics because of the cost factor. Others are still toying with the discredited fire-medic model; this despite the outcry in Owen Sound, where the past mayor was resoundingly defeated on this issue. The fire-medic experiment will not cut costs or improve service. Ambulance dispatch is in crisis. There are chronic staffing shortages at the 11 provincially operated central ambulance communications centres because pay rates are so low that the retention rate for new hires is only 30%. Ontarians are dying because the last government wouldn't address this crisis.

Mental health: The reckless Tory mental health agenda closed psychiatric hospitals and downloaded the costs of community programs. The divestment of seven provincial psych hospitals has resulted in massive bed closures and cuts to programs. Money promised to community programs never materialized. There has been no increase to base funding in 12 years. People with mental illness are on our streets and in our justice system. Patients are discharged with limited follow-up because of too few general practitioners and psychiatrists. The Tory record on bed closures is shameful.

OPSEU members are on the front line. We want to strengthen medicare. We want stability in the health care system. We want fair funding for the public services we deliver. We want to be paid fairly for the important work we do.

I'll turn the floor over to Leah now.

Ms Casselman: The Ontario Health Quality Council, as set out in part I of Bill 8, is intended to monitor and report to the public on access to publicly funded health care services, human resources in publicly funded health services, consumer and population health status and health services outcomes.

We would ask that the Ontario Health Quality Council also be required to report on the extent that the Ontario health care system complies with the CHA principles of public administration, comprehensiveness, universality

and portability and on issues relating to two-tier medicine, extra billing and user fees.

During the tenure of the previous government, we witnessed a serious erosion of democratic control over the health care system. We strongly recommend that the council should only be appointed by cabinet once assembled through an inclusive, representative process that does not include for-profit providers, given their obvious conflict of interest.

In addition to the requirement that the council deliver a report on the health care system each year to the public and to the minister, we would also give the council the power to make recommendations on the future course of actions to be undertaken.

We support the section in Bill 8, subsection 9(2), that extends the prohibition against extra-billing by physicians and other designated practitioners. However, another section of the bill, subsection 9(4), may well open up the possibility for the government itself, through regulation, to allow extra-billing and opting out.

We support a ban on extra billing and opting out and would request that the act be absolutely unequivocal in this regard. Both should be banned. Block fees should not be allowed, in regulations or anywhere else.

Queue-jumping: We commend the inclusion of section 15, the intent of which is to limit the ability of individuals to jump the queue. But the section must not be limited to insured services. As the list of medically insured services is restricted, this provision would not protect those seeking delisted or as yet unlisted services from queue-jumping. The major threat, however, is not the occasional queue-jumping abuse, but rather the systemic shift from public to private, for-profit health care services.

Accountability agreements and compliance directives: The original wording of the bill gives the Minister of Health broad powers without any form of democratic control. It allows the minister to order fundamental changes to our health care system with little or no public consultation, procedural safeguards, transparency or other checks and balances. It appeared to give the minister the authority to order individuals and organizations to comply with ministerial initiatives and to enforce compliance through regulations that are still unspecified. The original wording of the bill appeared to allow the province the ability to open and change collective agreements. In his remarks to this committee on February 16, Minister Smitherman said the bill was not intended to do so, although he acknowledged unions have widely interpreted Bill 8 to read that way.

We have reviewed the amendments provided by the minister on February 19. With the exception of the amendment excluding trade unions from the definition of health resource providers, agencies or entities, the draft amendments fail to address our many concerns about Bill 8. The bill should not grant arbitrary powers to restructure health care. It should promote transparency and democracy and not unilateral ministerial powers.

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We have recently received troubling signals from this government about the sanctity of free collective bargain-

ing, and the entire accountability agreement section of Bill 8 heightens these concerns.

Further, according to section 20 of Bill 8, the minister, in exercising his or her powers, is to consider “fiscal responsibility, value for money and focus on outcomes.” We want a high-quality health care system. We desire value for money and fiscal responsibility too. But in our experience, terms such as these are often code words for bringing in the for-profit sector. Our members are committed to public medicare and are opposed to any such language if it means bringing in more private sector involvement and profits.

While the motivation of the government is not entirely clear, part III of the bill can only be seen as an attempt to grant the minister unlimited power to dictate fundamental changes in the health care system without safeguards or democratic input. The powers and penalties in the bill are all stacked on one side. It is not on the side of those who want democratic representation and transparency in a medicare system supposedly designed for them. Accordingly, we call for a complete withdrawal or at least a rewrite of this section of the bill.

What would a true commitment to medicare include? It would include initiatives to rebuild comprehensiveness and to stop delisting, to protect and rebuild universality, and to restore accessibility to publicly funded services.

It would also be to improve public access to information, including financial information about health care institutions and sectors; to put in place public control, public governance and democratically elected boards; to restore full access to home care, including home nursing, homemaking and personal support; to improve access to primary health care; to improve access to drugs, treatments and assisted devices; to put a stop to creeping privatization and Americanization of health care, as promised in the election campaign; to create a democratic health council that reports on extra-billing, user fees and two-tier health care; to stop delisting of medically necessary services and to restore access to previously delisted services; to stop queue-jumping for so-called medically unnecessary services; to enact whistle-blowing protection for those employees who complain about poor practices; to stop P3 hospitals, private MRI and CT scanning clinics; to stop divestment of psychiatric hospitals, bed closures and program cuts pending a full review of the crisis we face today in our mental health system; to fully disclose OHIP delisting, physicians’ out-of-pocket fee list and other charges; to invite input from health care workers, patients and clients of the health care system; and to commit to public health through provincial laboratories and public health units.

You’ve already heard from many OPSEU front-line health care workers in your hearings across this province. They have painted graphic pictures of the issues they face. We hope we’ve added to that picture here today with our remarks.

In closing, we would ask that this government hold fast to its campaign promise to restore our cherished health care system. You can show your leadership and

your commitment to change that works by empowering a health quality council that is truly accountable and can make recommendations for change, assembling the council through an inclusive, representative process, exclusive of for-profit providers, and banning all privatization initiatives, reversing the P3 deals already in the works and putting all private MRI and CT clinics back into the public sector.

To ensure that Bill 8 passes the tests of accountability, free collective bargaining and a commitment to the principles of the Canada Health Act, we believe the bill should be rewritten. We thank you very much for this opportunity to make our presentation.

The Chair: Thank you, Ms Casselman and Ms Rout. That was extremely well timed. You used up exactly 20 minutes and didn't leave us any time for questions, unfortunately.

Ms Casselman: We've done this before.

The Chair: We can tell. Thank you very much for coming today. Your input certainly was appreciated.

ST MICHAEL'S HOSPITAL

The Chair: Our next delegation this afternoon is from St Michael's Hospital. I call Jack Petch forward, with Jeffrey Lozon and Wendy Cecil. Make yourselves comfortable. Welcome. You have 20 minutes. You can use that any way you like. At the end of the presentation, if there's any time left, we're going to split it among the three parties for questioning.

Mr Jack Petch: We will save some time for questions, because I think it might be helpful to the committee to wonder about some of the things we talk about.

The Chair: Wonderful. It's 2:54.

Mr Petch: I'm Jack Petch, chair of the board. Next to me is Wendy Cecil, who's our vice-chair. Wendy's background is with the governing council at the University of Toronto, where she is the past chair and is currently involved in the U of T president's circle. Jeff Lozon is our CEO.

We're here on behalf of St Mike's, obviously. Just to give you a touch of history, but not much, our hospital was founded in 1892 by the Sisters of St Joseph to care for the sick and poor of Toronto's inner city. That is something we continue to carry on today.

We're going to tell you things I'm sure you've heard before from other people in different ways, but we're going to try and add some real-life part of it as to how we deal with some of the things we're going to address and some of the concerns you might have.

We also operate as a referral site for high-acuity services, such as heart disease and trauma. We share with Sunnybrook the trauma activities in and around the city of Toronto, as one of the two trauma hospitals. We have an annual budget of approximately \$400 million. We have 600 in-patient beds and a staff of 4,700. We have 600 physicians, 1,500 students and 500 volunteers. We are also a teaching hospital affiliated with the University of Toronto and provide teaching and experience to a

significant number of medical students who go through our hospital.

What we would like to do is to focus on just a few points in Bill 8, rather than on everything, but we will note that we adopt a lot of the position that the OHA has taken. We think there are a lot of very good ideas there.

We also note Minister Smitherman's comments of yesterday, in which he said there should be a sustainable financial footing for hospitals. We would interpret that as there being an ability on our part to do long-range planning with the government so we know, on a going-forward basis, what is expected of us and what we might expect from the government.

A culture of accountability and results is something we support 100%, and I'll touch base on that. The creation of strong community health care services: This too is important to us, because one of the costs we incur is keeping patients in our hospital longer than they need to be there because there is no place to send them. So those are things we're strongly supportive of.

We're going to touch on four key points, pointing out that today we are very accountable to the government, not only accountable under the Public Hospitals Act but, in our case—and Wendy will touch further on this—accountable as a matter of practice, that how we run the hospital, the undertakings we have, the responsibilities we see to the people of the province of Ontario are something we adopt and follow today.

The negotiation of accountability agreements: We see those too as something that should be negotiated, not imposed. We see it as something that would address the needs of the public, of the government and ourselves. I think a good, living example of that would be St Michael's undertaking of SARS 2 the summer last, where the province approached St Michael's Hospital to be the lead hospital in dealing with SARS 2. We had discussions, we expressed our needs, we expressed our concerns, and through that, we arrived at an understanding with the province as to how we would deal, as the lead hospital, with SARS 2. I think that's a very good example of how things could be dealt with, where rather than having something imposed on us, we have discussions that lead to better health care for everyone.

We would stress that the agreements that are entered into and to be entered into should be between the hospitals and the government, not between hospital executives and the government. That is something we feel very strongly about. It's we, the hospital boards, that are accountable, and those discussions and negotiations should take place at that level, obviously with the input and background of the CEO and the hospital executives. That, to us, is the proper procedure.

We also bear in mind and note that, as you heard yesterday, we are a part of the Catholic Health Corp of Ontario health care system. In that sense too we have another constituent that we work with.

Likewise, even in exceptional circumstances, directives should be addressed to hospital boards, not to executives. Again, looking at how we run our hospital,

we develop a budget in consultation with the medical staff, in consultation with the needs of our patients, in consultation with the province. The board sees that those are addressed and maintained. We see a dialogue in this case, and then if there are issues, they can be dealt with directly through the board.

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Jeff, as our CEO, develops on an annual basis his objectives; the board approves those. We see that Jeff is accountable to us, we see that he meets the commitments he makes to us, and we assess him on a regular basis. Likewise, we assess ourselves as directors: Are we doing a good job? Do we fully recognize and appreciate the responsibilities we have for public funds?

To give you a bit of a sense of that before I get into the more formal part, I look at our board, and our board is a group of people who work together, who have come from various backgrounds, who have various skills and interests. We have committees.

We have a business committee, and on that committee we have people who run public companies, who run private companies. They understand the business aspect of running a hospital.

We have an audit committee. The head of our audit committee is the former head of one of the national accounting firms. We think this is important, but what does that do in providing health care?

Well, we have a community advisory committee. We talk to our community, we understand their needs, and we ensure there are community representatives. We have a senior person from Regent Park on our board. We have the executive director of the YWCA on our board. So we don't lose touch with those to whom we provide our services.

We have a pension committee. Obviously, everybody suffered through the downfalls of the marketplace, so on that committee we have people who are in the investment business and can hopefully lead us in the right direction.

We have a research and academic committee, because, again, we are a teaching hospital, and that allows us to provide very high-level care in very acute circumstances.

So we recognize all the communities we deal with and we have representatives on our board. We have a very good board. We insist on attendance. As the chair, if somebody doesn't attend, I want to know why. If they're not willing to make the commitment and follow through, they're not welcome. We see accountability in real-life circumstances.

I talk about fiduciary and accountability and so on. It's something we stress on a consistent basis. One of the best examples I have of that is our doctors. In many cases, our doctors pool resources. We would have a group of anaesthetists. There might be—pick a number—six who provide service, but there's a seventh, and that seventh is supported by the six to do research. This is part of our accountability, our recognition of responsibilities, that we do have these broader responsibilities to the community.

I'm jumping around a little bit. I'm going to ask Wendy if she would touch on a couple of things, and then

I'm going to come back to some of the other points we would like to make.

Ms Wendy Cecil: Thank you very much, Jack. Good afternoon, everyone. The first point I'll deal with is the transparent accountabilities that we believe already exist at St Michael's Hospital.

The board of St Michael's Hospital, like other hospital boards, takes our governance, fiduciary and legislative responsibilities very seriously. Our directors voluntarily demonstrate significant commitment, acting in full compliance with the terms of the Public Hospitals Act, hospital bylaws, related corporate governance legislation, and the recent legislation that affords the Provincial Auditor greater latitude in reviewing the financial performance of hospitals. All of these structures establish strong, transparent accountability to the government and to the public of Ontario.

At St Michael's, we are very proud of our long record of strong financial performance and demonstrated accountability to government and the public for the effective use of tax dollars. I'd like to give you two examples of our leadership in these areas.

First, St Michael's Hospital has had a decade of strong financial performance, demonstrating our longstanding commitment to fiscal responsibility and accountability for the resources provided by the province. St Michael's has recorded a balanced budget or better every year since 1991-92. Our performance is a direct result of the steadfast commitment of our executive team and voluntary board of directors, who work in a true partnership to ensure the transparent and just use of our resources in keeping with our governance and fiduciary responsibilities.

Second, the success of our merger with the Wellesley Central Hospital—which everyone affectionately referred to as the Wellesley—in the late 1990s is directly attributable to governance structures and processes that demonstrated our openness and transparency with all stakeholders throughout the transition process. When the Health Services Restructuring Commission directed us to take over operation of the Wellesley, the board of St Michael's Hospital quickly established an integrated governance model. Board members and senior medical leadership from the Wellesley were added to the St Michael's board of directors. Members of the St Michael's board stepped down in order to accommodate this. In addition, we expanded our board committee structure, specifically the membership and responsibilities of our community advisory panels that Jack mentioned a minute ago, to provide the external community with greater direct access to the board. These changes helped to build trust with our newly expanded community and demonstrated the value that our board places on being open, transparent and accountable to our internal and external communities.

In looking to the future, we support the intent of the government to continually improve the performance of the health care system. We welcome the introduction of a provincial health quality council. We believe that in order

to carry out its work effectively, the membership of the council should include representation from hospitals—both senior administrative and medical leadership. We were pleased to see this understanding reflected in the minister's draft framework for changes in the bill. We also encourage the government to expand the council's responsibilities to enable it to make substantive recommendations to the minister in respect of the operation of the health care system.

Next point: Accountability agreements must be negotiated and mutually agreed upon. The provisions of the draft bill require hospital boards to enter into accountability agreements and to adhere to government-prescribed performance goals, service quality and system outcomes. We support the concept of negotiated accountability agreements.

In the absence of a negotiated agreement, Bill 8 would transform the role of boards from that of a governing body into that of a government agency. Fundamental decisions about hospital services will be centralized in the hands of the Ministry of Health and Long-Term Care. The role of boards in the community would be rendered marginal. Communities will no longer have a voice in shaping the services available in their local hospital, such that Bill 8 risks disengaging communities from their relationships with hospitals. The environment will also severely threaten the capacity of hospital foundations to work with their communities to raise money for the provincially unfunded portion of capital necessary to maintain health care facilities.

In the minister's opening remarks to this committee, the minister stated clearly that accountability agreements will be negotiated and that the government and health care providers will work as partners to come to a mutual agreement on outcomes and performance targets. We support these statements. However, the minister's draft framework for changes is silent on these two issues. We note, however, that the OHA's amendments propose for a process of negotiating mutually acceptable agreements and dispute resolutions. We support the OHA's proposed changes and we would emphasize the importance of these processes being led by an independent third party.

One final note on this point: The bill is overtly silent on the notion of the mutual accountability shared by hospitals and government for the provision of health care services. In fact, there is no mention of the government's responsibility to provide appropriate and timely funding, and to work cooperatively with health providers to define service levels, the quality of care and the performance goals. In this regard, the bill fails to require the minister to act in the public interest in implementing performance agreements that will address the health needs of communities.

I will now ask Jack Petch to provide the remainder of our remarks.

Mr Petch: I'll begin by asking the Chair how much time we have left.

The Chair: You have about four minutes.

Mr Petch: You have our presentation here. I'm going to take one minute and save three for questions.

I've already mentioned that we feel strongly that the accountability agreements should be between the government and the board, not the CEO and the senior executives. Likewise we think that it's important that there be this kind of direct interaction between the board and the government. With that—you have our written presentation—let's take some questions.

The Chair: Thank you. You've left us about a minute each.

Ms Smith: Thank you so much for your presentation today. It's certainly well thought out and well drafted. I did note, however, in your opening that you failed to mention the fabulous research department that you have at the hospital.

Mr Petch: Thank you.

Ms Smith: Since I have a soft spot for the research department at St Mike's, I have to mention what a great job they do. I wanted to just raise the issue that you've seen the framework for amendments and you know that we're looking at accountability agreements being between the hospital board and the ministry. Moving along that line, you spoke a little bit about the fundraising and how it's impacted by the accountability agreements. Do you foresee any problems if there are accountability agreements between the board and the ministry?

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Mr Petch: Not if they're negotiated, I don't think. As you know, we don't get fully funded for capital, for equipment and so on, so we depend on our foundation to raise money. We just recently finished raising \$50 million to do all of those kinds of things. If it's freely negotiated and there is that kind of dialogue, no, I don't see that as a problem.

Ms Smith: OK. My other point was, you made reference to fiscal responsibility, balanced budgets—your history of fiscal responsibility is impeccable. Generally speaking, do you have an objection to the notion of accountability agreements between the ministry and hospital boards?

Mr Petch: We think it's a very good idea, because in a sense we have that now in practice and I think formalizing it would be to everyone's benefit. For example—and Jeff knows this better than I—we do a lot of heart care, and we don't get fully paid by the province for the heart care we provide. Our costs are more than that, and everybody knows that. I think that's the kind of thing we could negotiate in an accountability agreement.

Mrs Witmer: Thank you very much, Mr Petch and Wendy. I would certainly concur with Ms Smith that your hospital does a wonderful job of providing high-level, quality, compassionate care to the people in the immediate community and beyond, and we really appreciate the leadership that you have exhibited in responding to those needs.

We hear from your presentation and others that we know the government wants to get it right, there is a commitment to medicare, but there's a lot that remains to be done, particularly in the area of the accountability agreements and the whole issue of accountability. My

question to you is pretty simple: Before this would go back to the Legislature, once the amendments come forward from the government, would you like another opportunity to be able to come to a committee such as this to give your input one more time as to how you think the legislation could be further improved in order to meet that genuine commitment I know the government has to medicare?

Mr Petch: I think it would be helpful if we could see what it is one would see in an accountability agreement, what kind of things would go into it, with some suggestions. Then we could be more direct in our response and the kind of commitments we can make as a hospital.

Ms Martel: Thank you for being here today. You told the committee that you have seen the minister's draft framework for changes, so you will know that in section 22 the minister still retains the right to issue compliance directives or orders, which hardly sounds like negotiation to me. Second, in section 23, the minister retains the right to claw back CEO compensation or to apply other financial remedies to a CEO who is an employee of your board, not an employee of the minister. Given what is in the draft framework as we speak, can you tell me if that resolves the concerns that your board has with respect to negotiation versus imposition, or having to be in a position where the minister still has control over your CEO?

Mr Petch: I think it's important that the minister have some element of control over the hospital board. For example, if we make a commitment in our agreement and we're not complying with it, then clearly he should have the ability to issue a directive to the board to comply. I think that's important. But I think it's then up to our board to deal with the CEO. I don't think there should be a relationship between the CEO and the minister. I think the relationship is CEO-board, board-government. I think that's the appropriate way to go.

The Chair: Thank you for coming today. We really did appreciate your input.

GREY-BRUCE HEALTH SERVICES

The Chair: Our next delegation today is from Grey-Bruce Health Services, Brian Renken, board chair, and Pat Campbell, the CEO. If you'd like to come forward and make yourselves comfortable. Same as everybody else we've had before us today, you get 20 minutes. You can use that any way you see fit. At the end of your presentation, we'll apportion the time that's remaining amongst the three parties for any questions they may have. You've got the floor.

Mr Brian Renken: Thank you, Mr Chairman. I want to thank the committee for allowing us to make this presentation. My name is Brian Renken; I'm chair of Grey-Bruce Health Services. On my left is Pat Campbell, CEO for the corporation.

You have our written presentation before you. I'll try to skim through that, and I'd like to allow more time for questions if that's the committee's pleasure.

First of all, let me give you some background about Grey and Bruce counties. It's a relatively sparsely populated area. We have the highest senior population in Ontario, second-highest in Canada. So we have some serious concerns in terms of the elderly.

We also have a higher incidence of heart disease and stroke in our area, compared to the provincial average. We certainly have a challenge in terms of obtaining tertiary care for our clientele. As you know from the Romanow report, there's a clear distinction between rural Ontarians and urban Ontarians in terms of the type of health care that they are able to access. Obviously, the recruitment and retention of health professionals is a serious concern for us.

Let me just elaborate on how Grey-Bruce Health Services was formed. That was a volunteer amalgamation back in the mid-1990s as a result of the HSRC directives that were going on at that point in time. We've been able to amalgamate five hospital boards, and we presently operate six hospitals involving primary and secondary care, a medical clinic and a withdrawal management program, all under one governance structure.

Our main concern is to provide primary care that is integrated in the delivery of the health care system. We also work in partnership with the Grey-Bruce health network to create access to quality patient care and develop joint clinical pathways and health information systems for our constituents.

We feel, as was evident in the previous presentation, that there is a certain accountability that we have at the present point. We also participate in the hospital report series and have done so since the inception. We spend an inordinate number of hours trying to collect that data and then try to improve on the results from each survey that's done. We also have formal licensing and inspection through clinical areas in the laboratory, diagnostic, food services and pharmacy areas. We are accredited through the Canadian health council on health services. We've also participated in the third party review. We've asked for results. To date, we have not received that. We're presently open to the media at all of our board meetings and, as St Mike's indicated before us, we also have community advisory committees that are active in providing local input to what our hospital needs.

We have serious concerns about the impact that Bill 8 will have on our local accountability. We are concerned about what the board might be faced with if there are executive directives issued by the minister and what that would do to our local community. We feel that local community input is important and we're a little concerned that some of those directives may be coming from Toronto, as opposed to what the rural constituents really need. Grey-Bruce Health Services certainly has no difficulty with accountability agreements. We want them to be negotiated and agreed to well in advance. We don't want to be told what we should be doing.

Second, we have a concern about how they might affect our situation with our CEO. We want to have control over the CEO, and we're quite satisfied with the

way that is in place at the present time. We really consider that there will be significant resignations if this bill is allowed to proceed. We will have difficulty, in my opinion, accessing quality board members both to our board and to our foundations. We're concerned that if there's no public notification process prior to the minister unilaterally making changes, it could affect our overall health care system in our rural area. That's obviously a concern.

It's our submission that the minister should consider what's happened with the CACCs. Mr Watts spoke to that yesterday, and I think he was quite clear on what that has done.

We're concerned about the rate of care to delivery in low-density populations.

I'm the foundation representative on the board, and as such, I'm concerned about what this might do to the fundraising capability of the foundations. We have five foundations at the present time that are related to our corporation, hoping to raise approximately \$27 million over the next five years. We feel that the five foundations need to maintain a local community investment in health care, and it's our submission that the community's commitment to its foundations will be based on trust. If they don't have any faith in the fact that local decisions are being made for our local hospitals, then our capital fund-raising campaigns are certainly going to suffer. We would ask the committee to consider what's happened in other provinces. I am told that there's been a serious and dramatic failure when something like what Bill 8 is proposing is put into effect.

1520

In terms of the current performance agreements, we don't really have a major issue with performance agreements, provided that they're negotiated fairly and reasonably. We are already starting to work at some types of performance agreements through the planning and human resources area. We would ask the committee that any type of performance agreement would have to incorporate multi-year funding. There has to be a mutual agreement with joint accountability both by the government and by the hospital sector itself. Those agreements should be incorporated, as you've heard previously, with the board directly, as opposed to the CEO.

Suggested amendments that are referred to there: The preamble, in our submission, should include accountability by the government and, by necessity, should incorporate a good faith element. The principles should include negotiated performance agreements. You should be rewarding good governance; you should be incorporating community involvement in the health care system so the stakeholders have a say; and you should, with respect, make decisions—or the minister should make decisions—based on public interest, as you've heard from the previous presentation.

One suggestion is that the arbitration mechanism of the agreement should allow for some kind of resolution if the two parties cannot come to terms on an agreement. The term should be three years, as was referred to in the

written submission. We have great concerns with sections 25 through 32 and the consequences, and amendments should be put in place that deal with those non-compliance issues.

We've suggested that there may be some substantial implications for the province in a couple of areas. As the government seeks to reduce the escalation in spending, the resulting health care deficit will land firmly at their feet, in our submission. We firmly believe that directors will abandon their roles and contribute to other volunteer activities as opposed to being merely an advisory committee for the minister. Communities certainly would lose their influence over how services are delivered to them and how the local hospitals are managed. We believe that the opportunities to build on local hospital network initiatives to create an integrated system of care would be lost—in effect the silos will be intensified. That's something I understand the minister wants to try to avoid.

Lastly, when it comes to leadership, the constraints and personal penalties associated with the performance agreements will, in our view, drive CEOs from the industry. We need exceptional leaders who are innovative and creative and are interested in furthering the health care of our constituents. Obviously, recruitment of physicians to medical leadership positions in the board, which is a difficult task at the best of times, will certainly become impossible if this bill is imposed.

Our final recommendation is that there be a provision for the public to respond to any proposed amendments and to re-open the hearings for input at that point in time. We'd ask you to consider learning from the experience of other jurisdictions, such as British Columbia. We want you to be alert to the inconsistency that the government appears to be following at this point when it relates to school boards compared to the health care industry.

I want it clearly understood that Grey Bruce Health Services is 100% in support of performance agreements between the hospital board and the ministry, but we would ask you to pay critical attention to how the performance agreements are drafted, perceived and implemented.

Thank you for the opportunity of speaking.

The Chair: Thank you, Mr Renken. You used up about 11 minutes, which leaves us with nine.

Mr Arnott: I have a question. First of all, I want to compliment you for coming in today. We certainly appreciate the views that you've outlined. I'm sure you are aware I represent a riding just to the south of you, in Waterloo-Wellington, and 75% of my riding is small town and countryside, so many of the issues that you face are similar to ones we face in Waterloo-Wellington in our small hospitals.

I received a letter from Gil Deverell, who is the chair of the North Wellington Health Care Corp, which is the amalgamated board of the Palmerston District Hospital and the Louise Marshall Hospital in Mount Forest. Gil is somebody I've known for a long time. He talked about this bill: "While some ... aspects of the bill are laud-

able...." But he went on to say, "However, from my viewpoint as an active participant in hospital governance in rural Ontario for some 25 years, Bill 8 is a serious threat to the successful continuation of public hospital governance by local boards made up of volunteers from the community."

He goes on to say, "The bill explains that the accountability provisions in part III allow the minister to 'require the entering into of accountability agreements and to issue compliance directives' and 'to reward' compliance or 'deal with' lack of compliance." I think he sees that as, maybe not threatening language, but certainly ominous language.

He continues on, "If the Ontario Legislature no longer has confidence in the ability of our hospitals to be governed by local volunteer boards who are responsible to the public served by the hospitals, then that declaration should be made openly and should be the subject of public input and debate."

Do you agree with these statements?

Mr Renken: Absolutely. I'll let Pat speak to it but, very briefly, I think Mr Watts yesterday referred to the Trojan horse issue in terms of taking away the volunteer boards. That's an extreme concern for me personally, and I think it's the wrong way to go.

Ms Pat Campbell: I guess the comment I would offer is I've been in Grey-Bruce three years now, and the realities of providing health care in a geographically broad area are very different than in the high-density populations in the urban areas. Those realities are not well understood for people who have not tried to operate in those environments. Decisions get taken based on looking at the numbers, as opposed to looking at the realities of trying to maintain a system of care at some level that's available to the public.

Speaking for Grey-Bruce in particular, we have tremendous weather concerns and the reality of level 1 paramedics, which make the need to have close access to emergency care quite significant, as opposed to having advance-care paramedics. Those issues are very real for our population, and not, to my understanding, well understood for people who are dealing with the broad health care system in total.

Ms Martel: Thank you for being here today. You said you participated fully in the third-party review process and the results have never been shared. You're not the first person to tell us that, and I hope the parliamentary assistant can get those reports out the door to these people who work so hard—this and in Ottawa. Just a suggestion.

Near the back, under "Implications for the Province," you said, and you were quite direct, "Directors will abandon their roles and contribute their volunteerism to other causes where their efforts will make a difference because they will only be advisory if the ministry is directing the CEO."

If you have seen the revised framework that the minister is now operating from, where new amendments will come from, it still says in section 23, "CEO compensation clawback or any other financial remedies

to be applied to a CEO," by the minister, "as a last resort only after all due process," but he's still the minister at the end of day and has that power.

Does that qualify for you as the minister directing the CEO, if the minister at the end of the day has control over compensation and can apply financial penalties?

Mr Renken: I'll take the question. Very few times has our board become politically motivated, but when they saw this provision and the provision in Bill 8, they wanted us to make a presentation. So we're fundamentally opposed to that being allowed.

Ms Martel: So you haven't been convinced that in the direction the minister now wants to go, which was released to us last Thursday, there has been any change there that would give you any comfort.

Mr Renken: In our submission, it's not good enough.

Ms Martel: In the same way, in the same document, just the section above, in section 22, it does say that after due process provisions and after the minister has heard representation, there has been an exchange of documents and information etc, the minister will still have the ability to issue compliance directives or orders. That's a far cry from, for example, a dispute resolution mechanism, which the OHA has put forward, I gather.

What concerns, if any, does that still give your board, that at the end of the day you might have notification, you might have some time to make your representation, but the minister still has the authority, then, which is unilateral, to impose compliance directives or orders?

Mr Renken: Once again, that's going to cause problems with our board. We want to be able to make those decisions. We don't feel that the minister should be able to do that directly with the CEO. It's something I think they're fairly adamant on, and they're not prepared to accept that. I think that's why we will lose some board members.

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Ms Martel: So what you've seen to date, both in terms of the original bill and then the proposed changes, is not giving you the comfort you need to say to your board, "Stay on. Things are going to be OK"?

Mr Renken: It has not.

The Chair: Ms Smith.

Ms Smith: Thank you for coming in today and providing us with this presentation. I want to follow up on something Ms Martel just said. First of all, I'd like to thank Ms Martel for her advice; it's always nice to have. I also want to ask: You are of the understanding that in the framework that's been provided, the accountability agreements will be between the board and the ministry? That's what we foresee in the amendments that should be presented.

Mr Renken: I've seen that.

Ms Smith: That still raises concerns for you about your board membership?

Mr Renken: It's still the same. We're still convinced that may not be an appropriate process.

Ms Smith: That having an accountability agreement between the board and the ministry would still cause your board concern?

Mr Renken: No, that's fine. We're quite prepared to have an accountability agreement. As long as it's between the board and the minister, that's fine.

Ms Smith: That won't impact on the membership?

Mr Renken: As long as it's negotiated and everybody has reasonable notice.

Ms Smith: That's great. That's what I was trying to get at.

You did make reference to the rural setting. Also, on page 6 in your presentation you say, "Service planning may not reflect care delivery required in low-density populations." We haven't had a lot of presentations from non-urban health care providers; we've had a few. I was just wondering if you could expand a bit on what concerns you might have that accountability agreements might not reflect the specific needs of a rural setting.

Ms Campbell: Accountability agreements are likely to make assumptions about how care is to be delivered that may not reflect our reality. I'll give you a specific example. The stroke strategy that's rolling out across the province identifies a particular mechanism to use in looking at the handicap to stroke patients around swallowing. That mechanism, to be blunt, did not work in rural Ontario. It implied there would be a team that would be trained and able to carry out this service on behalf of all parts of the hospital that would have need for stroke care. In reality, we have 11 hospitals in the province, and a team is not going to be able to perform that function. That reality had to be taken into consideration, in terms of our planning and our service design, and had to be quite significantly changed to allow that to be carried out. That would be a specific example, out of the stroke strategy, where there is an assumption that the care delivery model that works in an urban centre can be applied to a rural centre.

Other similar issues come up around the availability of health human resources: an assumption that you would have ready access to all kinds of health human resources that frankly my population doesn't have access to. Those would be a couple of specific examples.

The Chair: Thank you for coming today. We certainly appreciate your input.

SOUTHLAKE REGIONAL HEALTH CENTRE

The Chair: It had been our intent at this time to hear from Ms Olga Kremko, who is not with us, but I understand that our delegation from Southlake Regional Health Centre is here and is prepared to go ahead a few minutes early. Is that correct?

Mr Stephen Quinlan: Yes.

The Chair: Come on down then, if you would. Welcome. As you make yourselves comfortable, I'll explain the rules a little bit. You have 20 minutes. Use that any way you see fit. If there is any time left at the end of the presentation, we'll split it proportionately among the three parties. If you would introduce your-

selves for Hansard, it would be appreciated. The floor is yours.

Mr Quinlan: Thank you, Mr Chair and members of the panel. We will each introduce ourselves as we present. My name is Steve Quinlan. I'm a member of the executive committee of the board of Southlake Regional Health Centre. By way of introduction, I'm also the past president and chief executive officer of Seneca College in Toronto. I volunteer my services not only to this board but also to the province of Ontario through the board of Ontario Exports Inc, which you know is the arm of the Ministry of Industry and Trade designed to assist Ontario manufacturers in exporting their goods and services. I also volunteer as a board member of the Canadian Education Centre Network out of Vancouver, British Columbia, which is designed to bring international students into Canada. I serve on the board of D'Youville College in the United States, which provides Ontario with 800 to 900 students every year who fit into our elementary and secondary schools as qualified teachers. I also provide educational consulting services around the world as a volunteer, and recently worked in South America, the Far East and the Middle East.

I use this by way of introduction, because I feel that my qualifications and experience may even be very pale in comparison to the sense of community spirit and giving that we currently enjoy on the board of Southlake Regional Health Centre. It truly is a focus on our society and our community that has transformed Southlake from a rural community hospital in northern York region into a regional tertiary health centre whose programs serve a population base of 1.3 million, which has grown over 400% in the last 30 years and represents one of the most diverse populations in Canada, with over 50 different languages spoken on our streets daily.

At the outset, I must say that this vision of transformation, which I referred to earlier, initiated some 10 years ago, would not have materialized had it been left exclusively to the Ministry of Health. The obvious concern of the ministry in the last decade has been cost containment, despite an overwhelming increase in population within the 905 area and a complementary increase in the aged population. Indeed, we live in and serve the fastest-growing community in Canada. We don't dispute for a moment the ministry's intention or focus, and we would go so as far as to say we understand it, given the economic reality of the last decade. But having said that, government cannot and should not deny a growing population the health care it needs. Indeed, I would be remiss if I didn't suggest to you that government has a moral and ethical obligation to respond to those needs.

Our progress as an organization was premised on an evidence-based approach to decentralization of tertiary services closer to home. It is a long commute from our community into Toronto. Those improvements came through extensive ongoing negotiations with the governments of the day in a very sincere and genuine attempt to address the increasing needs of a rapidly growing and, as I referenced, increasingly diverse community.

Yes, we did prevail in having an agenda of growth in tertiary programming adopted by the Ministry of Health. This accomplishment was accommodated successfully because of the many checks and balances that were implemented throughout an ongoing process of justification and planning. This due process was not an enjoyable element of the progression I have noted over the last 10 years; however, in hindsight, our dogged determination and the ministry's cautious and systemic approach were forces that were required to ensure these complicated and comprehensive programs would be planned appropriately.

Bill 8, specifically sections 22 to 28, will ensure that this type of innovation and what we refer to as visionary leadership by a board and its administrative staff will never occur again. Is this really what each of you wants in one of the fastest-growing electorates in Canada? Instead, we suggest that a sincere and genuine commitment to enhance the quality of life of our communities and increase the scope of services in a rapidly growing and aging region will be penalized severely, without due concern for the public interest. In addition, I ask you to reflect for a moment: What competent and committed CEO would risk his or her career pursuing a growth-and-quality agenda when exposed to a law containing sections 27 and 28 of the current Bill 8? Those who would remain would be followers, not leaders; bureaucrats, not CEOs. Their focus would essentially be one of "Yes, Minister," not one that would inspire and motivate our medical staff. Community needs and concerns would be fleeting considerations, and it would not be long before it would take four months to get a doctor's appointment, just as it now takes four months to get a plastic birth certificate.

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This is not supposition; it is a fact that any reasonable, objective and informed constituent would conclude in reading Bill 8, based on its tone and its unprecedented attack on community boards of hospitals and their CEOs. It is intended, in our view, to quell the visionaries in health care and punish in an unconstitutional fashion those who would challenge the fiscally driven intentions of the province as they relate to health care.

Should we strive for greater accountability in health care? Of course we should, and we must. How can we do that? We refer you to page 2 of our submission, where we have identified 13 key performance indicators. We could well identify a further 13, and we believe this is something that should be seriously considered.

Can we demand efficiency and effectiveness in the delivery of health care? Yes, no question about it. We, as a board, have an obligation to do exactly that.

Should we encourage a responsible and innovative provincial focus as it relates to quality in health care? Yes. It is overdue and is anticipated eagerly by all providers and volunteers who respond to any element of our health care services. But should we accomplish this increased accountability through a bill that threatens and punishes the very providers and volunteers who have delivered unselfishly in the past? I think not.

To treat so shabbily and disrespectfully our health care providers and volunteers, without whose help we could not run our hospitals, would imply that the Ontario health care system, our hospitals and our providers are failures and have acted irresponsibly in shaping the current system. The evidence to the contrary is indisputable. Ontario remains the most efficient and effective province relative to hospitals in all Canada, and this accomplishment was realized despite the lowest per capita allocations and the lowest per capita acute care bed complements in a province characterized as the economic engine of Canada.

On a very personal note, my first read of Bill 8 left me feeling ashamed and culpable for something I must have been party to that was wrong or irresponsible, but in my heart I know that not to be the case. Surely, to have a government feel compelled to wield this type of power localized under any one individual and to have his or her sights levelled toward hospital boards and CEOs left me feeling ill, to say the least. As a trustee of a busy 905 hospital, I said to myself, "Was I party to some irresponsible, misguided plan, which had as its intent the bankruptcy of the health care system, with no consideration for patient care or fiduciary responsibilities?" I know that was not the case. Neither I nor my fellow board members felt that way.

All of our board are responsible people: active and retired chief executive officers, senior executives of major provincial institutions or corporations, or professional people who have been held accountable all their lives to shareholders, investors, customers, regulatory bodies or the like. We know what accountability is, and we know what accountability is not. Let me assure you that accountability is not bureaucratic control. Let me repeat that: Accountability is not bureaucratic control. What is it, then? It is leadership, vision and fiduciary responsibility, all of which we practise on a daily basis.

I wish to suggest that accountability is a two-way street. Members of the Legislature have responsibility and accountability to the people of Ontario. Accountability goes both ways.

In December, we opened a cardiac care centre at Southlake Regional Health Centre. It's been operating for three months. Every day of the week, we operate on patients. Our wards are filled with those patients. To date, we have not received five cents in grants from the government for this service. We're financing it entirely ourselves.

In three months' time, we opened approximately 100 new beds. We have no equipment, and we have no furnishings. We are still awaiting approval on our capital budget for that facility. Indeed, it may be done and it won't open for use by the public. So I ask the question: Is that accountability? I phrase that in the context of accountability being a two-way street.

I feel proud to serve as a volunteer trustee on a board that represents my community hospital. I welcome increased accountability and any development that will benchmark quality initiatives so all elements of our system will benefit. Appropriately structured and nego-

tiated accountability agreements are perhaps timely and required additions to the complement of checks and balances we utilize on an ongoing basis to maximize our efficiency and our effectiveness in the delivery of health care in this province. Nevertheless, we firmly believe that all the aforementioned developments can be achieved without sections 22 to 28 of Bill 8.

I would ask the panel to seriously consider the Southlake submission, which highlights our objections to Bill 8 and also emphasizes the positive elements of increased accountability in health care when done right. We are not asking you to do this alone. We would welcome the opportunity to work with you to achieve mutually beneficial outcomes.

The official submission, endorsed through signatures of the entire board, will no doubt provide a less personal analysis of this bill. Yet the conclusion remains the same: Bill 8, even in its recently revised form, is inappropriate and will lead to the elimination of community boards throughout the province. I conclude by asking this panel: Is that what you really want?

Thank you for the opportunity to make this submission. I'll turn it over to my colleague Nancy.

Dr Nancy Merrow: Thank you for the opportunity to address the committee today. My name is Nancy Merrow. I'm a family physician with a sub-specialty in palliative medicine. I speak to you today as the acting president of the medical staff of Southlake Regional Health Centre, representing physicians practising at our centre.

By strange coincidence, I happened to be under the weather yesterday and had the opportunity to watch the committee on TV. I'm very impressed with the process here and how organized you are and how fair it's been—very timely. I was looking forward to coming down today.

It's clear from the tone of all the presentations I was able to watch and from the little I've heard today that we share the same struggle: How can we meet the needs, wants and expectations of Ontarians and their families—who are an increasingly health-savvy, aging population—within available resources?

I've submitted a letter to the committee, and my remarks will not repeat that but only reflect some of the main points.

I have three points to make, and the first is regarding availability of physician services under Bill 8. Bill 8 eliminates direct payments to physicians for insured services. This affects our hospitalists, pathologists and physicians providing mental health services in hospital programs. Long-standing inequities in the OHIP fee schedule have made these kinds of alternative payments necessary. Please don't destroy one if you can't fix the other.

The second point is that the physician human resource pool is a fragile one. The bill sends yet another message to providers that somehow we are part of the problem and that if we could just be more accountable, the system's problems could be fixed. In this time of phy-

sician human resource crisis, this is the wrong message, that somehow we aren't doing enough to control costs. Providers need to hear that the minister is joining the effort to meet the needs of Ontarians and their families, not abdicating his accountability to already overburdened providers.

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The third point is that my presence here today with my colleagues from the hospital board and foundation reflects how our organization responds to a perceived threat to our ability to care for our patients. Physician leaders, board members, foundation and administration work together effectively and locally to act on behalf of the community we serve. Bill 8 directly dilutes and diminishes the responsiveness of our board and CEO to the needs of our community. I do not want to see this advocacy ability eroded.

I would appeal to the committee and, through Ms Wynne, to the minister for a more collaborative approach to getting a handle on matching needs and expectations with resources. To devolve accountability when resources are centrally controlled is a recipe for disaster. Bill 8 alienates the volunteers and professionals on whose goodwill and dedication the system survives. I urge you to make the amendments necessary to present to your provider partners the spirit of shared responsibility needed to move ahead with meaningful reform.

Ms Carol Oliver: I'm Carol Oliver and I thank you for giving me the opportunity to be here today. I am the president of the Southlake foundation. I've been in the fundraising business for 24 years, 11 of those years at North York General, seven when it was York County and now Southlake. Over this time I've raised well over \$100 million, with the help of many affluent, influential volunteers. I'm also the past chair of the international board of the Association for Health Care Philanthropy. So I've had the opportunity, as Steve has, to get around the world a little and look at health care philanthropy.

You have a letter signed by the chairman of the foundation board and myself, so I'm not going to read that. I simply have three quick, but I think important, points I'd like to make.

The first point is, I believe there is a very real risk of significantly fewer charitable dollars coming to hospitals as a result of Bill 8. At Southlake we're now raising the final \$1 million of a \$16.5-million campaign. We're funding a new emergency, a new regional cardiac, as well as new cancer facilities. We've received over 8,000 donations for the campaign to date. Why did those 8,000 people give so generously? Because they love the quality of care and they respect the leadership of the board and the management of Southlake. Southlake will be launching yet another, larger capital campaign in the very near future to fund the new regional cancer centre, and I feel that this incredible power of community participation will be at risk. People are not motivated to write a cheque to the government. We have 42,000 donors in our database and they're all ready to help Southlake. I believe there are many campaigns in Ontario that will be compromised.

My second point is, I believe there will be increased fundraising costs due to the added expenses of foundations just trying to convince donors that there is some local ownership. As a fundraising professional, my performance is based not on the dollars I raise but on the cost per dollar raised. I want the money going to the hospital, not to PR firms that are developing messages that try to convince people we do have some local autonomy.

The third and last point, but I think it's the most important one, is the risk of affecting the motivation of influential volunteers. The whole key to raising large sums of money is dependent on having an army of influential and, hopefully, affluent volunteers. These people are leaders. They are CEOs who are willing to work incredibly hard. You just put a goal in front of them and they want to reach it. But they also want the power to influence the gifts, to be absolutely sure that those gifts are meeting the primary needs of their community.

The power of these volunteers is really awesome. I had lunch today with the CEO of a firm that has \$1 billion a year in business. At lunch today he agreed to make nine calls. We discussed the range that should be asked for each of them. The lowest one was \$100,000 and the highest was \$1 million. We don't want to turn people like this off, or we'd be looking to the Ministry of Health for significantly more money to replace the millions that these dedicated volunteers would be raising.

The Chair: That was just about 20 minutes right on. Unfortunately, there is no time for any questions, but we certainly appreciate you appearing before us today.

OLGA KREMKO

The Chair: I understand the person who had previously been scheduled for 3:40 has since arrived. Olga Kremko, would you like to come forward. Make yourself comfortable. You have 20 minutes to make your presentation. If you would introduce yourself for Hansard, that would be appreciated. At the conclusion of your presentation, if there is any time left over, we will ask you some questions amongst the three parties.

Ms Olga Kremko: My name is Olga Kremko. I have been a citizen of Toronto all my life. I have participated in the Toronto Health Coalition and the Ontario Health Coalition, as well as other health-oriented things.

First of all, the preamble to Bill 8, the Commitment to the Future of Medicare Act, incorporates the principles of the Canada Health Act and the values of the Romanow commission. It does not mention that health care belongs to all Ontarians, as well as Canadians, because it is paid through our taxes. It does not include the negative aspects of the state of health care here in Ontario that have been introduced since 1995. These cuts were due to the federal budget of that year and made worse by the Conservative Party, which cut taxes to corporations and the wealthy. The preamble does not include concrete initiatives which show exactly how the present government would make certain we go back to the health care we enjoyed before 1995.

It does not mention the serious erosion of our public health system and to the universality, comprehensiveness and accessibility of our OHIP. This includes \$100 million of services that have been delisted from OHIP. Some 9,000 Ontarians have no access to a family doctor—this is what the Ontario Health Coalition has said—and 25% of the physicians in practice are on the verge of retirement.

Due to the restructuring of our hospitals, we have fewer hospital beds and staff. Many have died waiting for beds or operations and others are still suffering, waiting for operations. Many elderly and disabled, although they previously would be in hospitals, have been forced to go into nursing homes and homes for the aged. The workers in these homes do not have the expertise to look after these people. In addition, the proportion of beds that is held specifically for those who can afford to pay a premium for a semi-private or private room has risen to 60%. These people go without even basic care due to cuts, and staff have been reduced. Only those whose families can afford to pay for their own caregivers are well looked after.

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Budgets for food in these facilities are less than for people who are incarcerated in penitentiaries in Ontario. The meat is tough and sometimes food is tasteless. There are fewer fresh vegetables and fruits available. Some families try to compensate by bringing in home-cooked meals.

The public facilities have been forced to compete with the private facilities, which the previous government supported. The consequence is that they are now as bad as the private ones.

Homemakers and home support services have almost disappeared so that caseloads from 2002 to 2003 have approximately 115,000 people, including frail elderly, who are left at home to look after themselves.

Drug costs are high and inaccessible for a growing number of people. The hospitals or whoever is managing the drugs do not examine the drugs because the new drugs are just repeats of the old ones. The finance committee wanted the elderly to pay more for their drugs. Before 1995, seniors did not pay anything for their drugs. Seniors have paid taxes for most of their lives and are still paying them. They deserve to have their drugs free.

The bill supports the prohibition of two-tier medicine, extra-billing and user fees. However, there are no specifics as to how they are going to do this. Fundamental to the universality of the public health system is the prohibition of two-tier medicine and extra-billing. In addition to the two-tier system mentioned above, there is two-tier health care, which is privatization. For-profit health corporations make a profit with user fees, service charges and two-tier access, the deleting of services and procedures for profit. Private laboratories charge fees now for pick-up and delivery and they affect long-term-care facilities as well as home care patients. Private MRI and CT scan clinics; people who pay out of pocket; medically unnecessary scans—those with the least medical need can jump the queue.

Service charges and fees for a whole range of services: Access to publicly funded physiotherapy, rehabilitation therapy and speech pathology is severely eroded. At some point within the next few months I have to go for physiotherapy, and from what I understand, I have to pay for it. Also, my mother had macular degeneration. There's a new drug that's out that can prevent macular degeneration. I am worried that I will get macular degeneration, and how will I be able to afford to pay for this drug? Apparently it cuts off at the halfway point.

Inadequate home care budgets led to massive cuts to home nursing, homemaking and personal support service. Those who can't pay go without and end up with preventable injuries and illnesses. To get on a doctor's list, doctors charge block fees to patients.

The health quality council is necessary to report on compliance with the principles of the Canada Health Act. The health quality council does not ensure reporting on to what extent the health system conforms with the principles and it's not required to make a report on issues such as two-tier medicine, extra-billing and user fees.

No person with financial interests in a for-profit health care corporation should be allowed to sit on the council. This arm's-length council should be composed of a democratically selected group appointed by all parties that represent patients, advocates and workers, as well as the so-called experts. They should include representatives from diverse groups, from geographically remote areas and from equality-seeking groups.

The purpose is to investigate how the health system conforms with the Canada Health Act principles of comprehensiveness, universality and accessibility and to report on two-tier access, user fees, service charges and extra-billing. It should have the power to make recommendations and to operate in a completely transparent manner. It should also report where the money goes.

You must stop the block fees and charges that create a barrier to access. It's a good thing that you're thinking of prohibiting physicians and other practitioners from opting out of OHIP, but the wording in the regulations allows the protection to be reversed. The government should not allow physicians to extra-bill by regulations. The college of physicians requires that the physicians allow patients to make the decision about whether or not they will pay block fees and cannot refuse a patient who will not pay in this manner.

It's good that you have the block fees under the control of the government. It allows the regulations of the bill to determine whether and how block fees are charged. Bill 8 needs to ban the practice. It violates the principles of the Canada Health Act. It is a barrier to accessibility. Physicians can charge on an item-by-item basis for the uninsured services. Severe shortages of doctors; abused patients; patients with few choices to leave a physician since they cannot find another one—they can't leave the physician they have even if he does ask for the extra fees.

The bill should address the transition to the team-based, salaried, reform primary care model used in com-

munity health care. Section 27 allows the minister to order fundamental changes in the health system with little if any public consultation, procedural safeguards, transparency or other checks and balances.

The system should be accountable to the people of the province and not to the minister—after all, we pay the taxes—and not publicly accountable in a top-down fashion.

There is no democratic control, no diverse representation on boards and governing bodies, no public accessibility to financial information about the health system. There's no whistle-blowing protection for health workers, no public consultation and meaningful input to changes in the health system, no democratic consultation prior to cuts, and no democracy and transparency.

Defunding and delisting: The important change is accountability to the people of the province. As I said before, they pay taxes for our health system.

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We have to stop privatization and ensure democratic, public, non-profit delivery of service. The P3 hospitals put millions of dollars of public funds into the hands of profit-seeking corporations for whom a veil of commercial secrecy obscures public scrutiny, over-profit taking and the misuse of public funds.

Higher borrowing costs, consultant fees, inevitable legal fees, outrageous executive salaries, fraud and profit-taking drive up the health care costs, making competing claims on scarce resources. In their endless search for profits, corporations seek new sources of revenues, imposing fees and service charges wherever they can. The motivation: the means for an increasing two-tiered health care system are increased. The result is the scope of services offered under the public system are refused. Beds and staff are cut, patients face a barrage of new fees, and two-tiering increases. Public accountability and access to information is reduced. Democratic control is reduced. Advertising, consulting and legal costs go up. Fraud goes up. Executive remuneration goes up. More and more of the health system is governed by a bottom line of profit margins and the rate of return for investors—which I understand is something like 25%.

We can provide masses of evidence from around the globe to substantiate these claims. Some of these are from England and Australia, where they end up paying two or three times what they would have normally paid if they had been done things the way they were before 1995, which is the federal and provincial governments, as well as the community, putting in money to bring in a hospital.

The creation of for-profit clinics to deliver hospital service poses serious threats to the sustainability of medicare. Access to good diagnostics is limited by the supply of equipment and trained personnel, that is, radiologists and technologists. While private clinics provide machines for which we ultimately pay, they do not increase the number of health professionals. The private clinics find their staff by poaching them out of public hospitals, leading to staff shortages in the public facilities.

In addition, they seek new revenue streams, including out-of-pocket payment for so-called medically unnecessary scans, a trick to get around the Canada Health Act. A person who pays for a medically unnecessary scan, as I mentioned before, jumps ahead of the queue, using up scarce resources for no reason and pushing back those with medical need in the waiting list. In addition, private clinics take the less risky and less costly scans, leaving the heavier-burden scans to the public system which has been deprived of personnel. They also take the third-party billing patients and those in WSIB, depriving hospitals of this revenue. These clinics make profits at the expense of the public health care system.

Also, I want all of you to realize that under the free trade agreements, once you privatize a system, you can't make it public. When you get the world trade agreements into it, you'll have thousands of corporations trying to get into the act. In the States, the HMOs are having really big problems. Some of ours, like Power Corp, are into the HMOs. They want to move into Canada because Canada is great big profit area for them. If you have something like cancer, the HMOs in the States won't even let you know, because it costs too much.

These P3 hospitals frighten me. I would be terrified of going into them, whether it's the one in Brampton or the one in Ottawa. I would be frightened because of their secrecy. You don't know what the heck is going on there. Also, there have been studies to show that people who go to private hospitals die a lot faster.

The Chair: You have about a minute left.

Ms Kremko: The main thing for our health care is that not only does the province have \$5.6 billion of debt, but all our municipalities have it. Not just all our municipalities but also our hospitals and so on have large deficits. I feel that what we should do, for the time being, is have taxes go up 2% to 3%. You can do this. The other government did whatever they felt like doing. This government can do the same.

The Chair: On that note—

Ms Kremko: Also, there is the Bank of Canada. It takes more to borrow from a bank, because they have to make a profit. But we have the Bank of Canada, where we can get money at a very low rate.

The Chair: Thank you, Ms Kremko. That would be a great note to close on. We're more than out of time. I did extend your time a little bit, because I knew you were in mid-sentence. We do appreciate your input today. Unfortunately, there's no time for questions. We do thank you for coming.

Ms Kremko: I will try to hand everything in by Friday.

The Chair: Wonderful. If you would, we'd appreciate that.

HEADWATERS HEALTH CARE CENTRE

The Chair: Our next delegation is from Headwaters Health Care Centre. Bob Baynham, the CEO, Brian Shannon, chair of the board, and Glenna Carr, trustee, are

with us today. Would you come forward and make yourselves comfortable. You probably have heard the rules by now, but I'll repeat them for you anyway. You get 20 minutes to use any way you like. At the end of your presentation, we'll apportion among the three parties any time that is left. If you'd introduce yourselves for Hansard, that would be wonderful.

Mr Brian Shannon: Mr Chairman, thank you for the opportunity of presenting some brief remarks to you and your colleagues regarding this important piece of legislation. My name is Brian Shannon, and I have the privilege of chairing the Headwaters Health Care board of directors. With me today are Ms Glenna Carr, one of the directors of the corporation, and Mr Bob Baynham, our chief executive officer.

Our hospitals are a source of pride in the communities we serve, which have been supported us on each and every occasion we have sought their support. I am convinced that we are well governed, well managed, have excellent and caring medical staff, and deliver health care very effectively.

We serve the county of Dufferin and the town of Caledon, which has a population of roughly 110,000 people. We're the result of a voluntary merger in 1993. We operate a 108-bed acute care facility in Orangeville and a 36-bed complex continuing care facility in Shelburne. Our budget is about \$35 million, and I have the pleasure of stating that this year our budget will be balanced, as it was last year. We received our full accreditation last fall, and every time we have applied for accreditation, we have received it.

We're not without our challenges. We are short about 13 family practitioners in our catchment area, which, as you can appreciate, is a major problem for us, and we really would like to enhance our mental health services.

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As I said, we're the result of excellent community partnerships, and our community has a great deal of pride, not just in our facility but in the care we give. We have received continuously exceptional financial support and have the privilege of being the first hospital in North America to have digital imaging.

I'd like to make it very clear that we do support the establishment of a health quality council and the principle of ensuring accessibility, and we're very pleased with the principle requiring accountability. However, I find it very difficult to envision a scenario where a minister of the crown would find it necessary to circumvent our board and ignore our history of excellence and effectiveness in the manner outlined in this bill.

Ms Carr will now make some specific comments regarding the legislation. If I may, I'd like to make some closing remarks.

Ms Glenna Carr: Thanks very much, and good afternoon. It's a pleasure to have the opportunity to meet with you at this late time in the day.

I would like to speak directly to the areas where the objectives of accessibility and accountability can be strengthened and improved by changing Bill 8. I have

three points to make. You have our presentation, so I'll speak to some of the recommendations and add to what you have in front of you.

Community hospitals are not just a public asset. They are a matter of civic pride and of community confidence that quality care will be there for us when we need it. They are often the emblem or the symbol of how Canadians define or distinguish themselves and their values. The strong connection between our community and the hospital is, in our view, put at risk by the new relationship proposed by Bill 8 that will put the minister between the local hospital board and the hospital staff.

Our board does feel accountable to our community, as well as to the government, for public funds. We believe that strong and effective hospital boards with decision-making powers and accountability for their decisions are essential to maintain strong community commitment and relationships between the communities and health care providers. You have heard from very eloquent speakers this afternoon on this issue.

In our view, Bill 8 blurs the responsibility by creating a dual accountability for the hospital CEO to a minister rather than simply and straightforwardly to the hospital board. The board should be accountable to the community and to the ministry, based on a mutually negotiated agreement. Therefore, we recommend that Bill 8 preserve the role of local boards to be responsible to govern and to enter into accountability agreements with the provincial government.

My second point, the power of the minister and boards: The minister already has draconian powers, some might say, under the Public Health Act. He can put hospitals under supervision, and there is an array of other sanctions available.

In our view, the Ministry of Health should focus on results and resources required, not on detailed implementation. It is local boards that should provide the governance oversight and set local priorities.

We recommend that section 27 be removed to prevent an override by the minister of the existing relationship, the employment contract or performance agreements that already exist between a board and its executive.

The next point is on how to have effective accountability agreements. We embrace the need for accountability agreements. In fact, our chief executive officer, Mr Bob Baynham, has been already working with the joint committee to develop agreements for hospitals that are realistic in setting targets and defining measures that respect the need for mutual co-operation and commitment by both hospital boards and the Ministry of Health.

We're acutely aware that one size does not fit all and that there is a variety of ways and means to obtain the desired results. We will all benefit from embedding in the legislation the principle of having mutually agreed and negotiated accountability agreements between boards and the ministry, but it will be much more effective and sustainable over time if the specific nature and content of the agreements can evolve and improve in policy and in practice, rather than in inflexible, detailed legislative fiat.

For example, to address health care as a system in the future, we may need to develop agreements that are multilateral and include community care and home care as well as hospitals. But let's learn to walk first and demonstrate that agreements between hospital boards and the government can in fact produce effective health care.

My last point is on mutual accountability and access. We believe that Bill 8 will be improved by recognizing that the minister also has accountability obligations, as well as hospital boards, to ensure that policy and resources are provided that will enable the achievement of medicare principles.

We believe that each hospital and community has access issues that must be addressed by the province as well as by local providers. In part, a multi-year funding commitment will help. However, we do have specific access issues that may differ from others. We do not all start at the same level playing field. It's not just a row of hospitals down University Avenue that we have in Shelburne and Orangeville. For example, we currently have no provision or resources for mental health and barely any for geriatric care. We have one geriatric psychiatrist who comes once a month. It doesn't seem to be enough.

We're also aware of unintended consequences that can arise. The Ministry of Health negotiates and signs agreements with the OMA. We live with the results. For example, recently an agreement was changed from a fee-for-service agreement to an alternative funding arrangement. This is a fixed price. It has impacted seriously on our wait times for emergency services. It was not the intention to do that; it was an unintended consequence. But that's something we're trying to improve. It was not our doing; we are trying to play catch-up with the result.

Therefore we think it's important that Bill 8 reflect the mutual accountability of both government and boards to ensure that the principles embodied in the legislation are not just lofty sentiments or good intentions.

Mr Shannon: I recommend that the members be very cautious in taking in any action that so clearly undermines hospital governance in this province. No one is well served by so cavalierly circumventing the relationship between a board and its chief executive officer.

I've been a hospital trustee for six years, and I sincerely believe that hospitals in Ontario are a source of pride, not a source of concern, as envisioned in this legislation. I suspect and am convinced that there are very few boards or hospital administrators who need external assistance in governing or managing these facilities. Delivering effective health care in this province is common practice. It's a result of the partnerships existing in and among our communities. The key to an effective provincial system is the continued support of the ministry, working in consultation with its partners, the community-based hospitals.

In closing, we agree with the principle of public and, more importantly, personal accountability and are content that the minister has the capacity to implement this now without this bill and specifically sections 22 to 28.

Performance expectations of both partners need to be clear, agreed to and committed to by boards and the minister. Accountability agreements need to be sensitized to local needs, programs and services and fiscal realities. The minister must commit to setting realistic expectations, establishing meaningful performance indicators, providing realistic and equitable funding and recognizing the systemic role and requirements of our partners, such as community care access centres, health councils and other community-based health service providers.

We'll entertain your questions, if you have any.

The Acting Chair (Mr Brad Duguid): Thank you very much. There are about nine minutes left for questions, so three minutes a side, beginning with Ms Smith.

Ms Smith: Thank you, Mr Duguid. It's nice to see you in the chair.

Thank you, all three of you, for coming. It's nice to see you again, Ms Carr. I'm very appreciative of your input. You are aware that there have been discussions ongoing with the OHA over a number of months with respect to this particular bill. We brought this bill forward for public consultation after first reading, knowing full well that we would need adjustments, and the minister in his statement last Monday did state that there would be adjustments.

Have you seen the framework for the amendments we are proposing?

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Mr Shannon: Yes.

Ms Smith: So you are aware that the accountability agreements we're talking about in this legislation would be between the board and the ministry, not the CEO. You did discuss a concern that there would be interference between the relationship of the CEO and the board. You are aware that the proposed amendments would include agreements between the board and the ministry, not the CEO; is that correct?

Mr Shannon: That's clear, but I think it's important to highlight that that can be done now. You don't need a piece of legislation to do that. I can't think of one board in this province that wouldn't co-operate with the minister in developing a performance agreement.

Ms Smith: Are you saying you don't see the need for accountability agreements at all?

Mr Shannon: No; they're a good idea, I believe. I'm very comfortable with the principle and the practice of them. It doesn't necessarily follow from that that it needs to be in legislation.

Ms Smith: As they're described in section 19, "an agreement establishing any one or more of, (a) performance goals and objectives respecting roles and responsibilities, service quality, accessibility of services, related health human resources," and on and on: Are those the kinds of things you would expect to see in an accountability agreement?

Mr Shannon: I think so, but as I said, you have to be very realistic. There are 100-odd hospitals and you're going to have to be very sensitive to the realities of each individual hospital, whether they're community-based,

the programs there, the services that are appropriate there. This is not a simple task. I think it's quite a dramatic task. It's a worthwhile task but you have to be very realistic in terms of how they're developed and how sensitive you are to the needs. The needs of our community are far different than any other community around. So it's a challenging thing to do but it's not a statutory thing.

Ms Smith: Absolutely. We have heard from a number of presenters over the last several days about the need not to have a cookie-cutter approach but an approach that would address the needs of the very different facilities and how you provide health care in your community the best way possible. So we have heard that, we've had a number of presentations on that and we appreciate very much your input today.

The Acting Chair: On to the Conservative Party.

Mrs Witmer: You mentioned digital imaging. I can remember having the pleasure of visiting the hospital when that was new and, you're right; you were first. Congratulations to Headwaters Health Centre. You've done an excellent job over the number of years that I've been familiar with the hospital as to the service you've provided to meet the local needs. We wish you continued success.

The one thing that's really impressed me as I've attended these hearings and read the submissions is the passion and the sincere commitment that board members on hospital boards in this province have to the hospitals they serve. I think it would be extremely unfortunate if, at the end of the day, the government did anything to eliminate the governance structure as it presently is and shifted power to the minister. I hope the minister and his staff and members of government have seen how well served the people in this province are by people such as yourself.

If you take a look at the fact that the entire part III, the accountability agreement, is the one that seems to be giving hospital boards the greatest concern—it has been suggested that it needs a total rewrite. The government has indicated that perhaps they are willing to step back and make some changes to the bill. If that's to be the case, would you support that those amendments would come back to a committee like this and you would have one more opportunity to give your input in order to ensure that the needs of your community would continue to be well served by the new legislation?

Mr Shannon: We'd look forward to that. I don't mean to be political, but I was quite surprised at the alacrity with which this piece of legislation hit the street. I think everybody should be more sensitized to each other before we present something of that nature to the assembly. There are lots of other ways to achieve what the minister appears to be wanting to achieve rather than through this bill. I really would recommend that we take our time. That's why I said to be very cautious. You don't need to be told about the number of activities that go on municipally and in communities that are volunteer-based. To cavalierly intervene there is fraught with risk, I

think. There is pride in every hospital in this province for good reason. Those communities built them. We provide a provincial service, but our communities built them and love them and care for them. So just be very careful.

I'm very concerned why anyone would intervene between our board and Mr Baynham. He has respect for us and we have respect for him. Why would you so quickly insult him and me and our colleagues on the board by intervening in that relationship? There needs to be some sensitivity here.

I'd recommend that you just slow down a bit and maybe rethink if there are ways to achieve what you want other than putting through a bill which—I'm an effectiveness nut, and I can't see the effectiveness dimension in the bill.

Mrs Witmer: Right. I think you said there is a need for more consultation.

The Acting Chair: That's it for your time. Ms Martel.

Ms Martel: Thank you for being here today. Ms Carr, it's good to see you in a different capacity. Welcome.

Let me start with something the parliamentary assistant said—because she said it to you and she has said it to others today: that there have been discussions and consultations etc going on about this for months. If that's the case, I can't understand why the government, through the minister, came back last week with a set of proposed amendments that don't resolve the concerns of hospital boards. They just don't.

Let me use the example you ended on, which was the government getting between the relationship between yourself as a board and your CEO. It's very clear in what we got last Thursday that section 27 continues to prevail. It says it would only apply to CEOs, but it still prevails. The minister can come in at any point and do a compensation clawback on your employee, without your input and without your approval. If there were consultations, how come that is still in this bill, in the proposed changes the government wants to make? Do you still have concerns?

Mr Shannon: I have concerns. I'm not sure if your question should be directed to me.

Ms Martel: Let me ask you another one. I've heard them say a couple of times now that there have been consultations on this for months. First of all, the bill wasn't introduced until about November 27, so it's hard to say it has gone on for months. Second, you would think if the government had heard the concerns, we would not have been presented with a two-page document last week that doesn't resolve the concerns.

The second area has to do with the power of the minister with respect to compliance directives and orders. The minister was in this committee two weeks ago and said that these things are going to be negotiated, but he comes back to us with a proposal that, at the end of the day, still says that he and he alone has the unilateral right to issue compliance directives and orders. I fail to see where the negotiation exists in that. It certainly is beyond the power he has in the Public Hospitals Act right now, which is, as Ms Carr said, pretty substantial now. If your

concerns had been listened to, don't you think that section would have been changed to reflect that we're going to get to this position but only after negotiations, and if we can't agree, maybe we'd have binding arbitration instead of unilateral orders by the minister?

Mr Shannon: I wouldn't even be comfortable with binding arbitration. I wouldn't be comfortable with any relationship where the government intervenes between the board and its CEO. It's just not appropriate in human resources practice, in law, in any way. It's just not a good activity. So, no way is that a palatable thing for anybody to be doing in terms of intervening between the board and the CEO.

Ms Martel: But this goes even beyond the CEO, because the minister, under that provision, could certainly issue an order or a compliance directive directly to the hospital board. This is over and above what he can do to your CEO. The minister has some powers under the Public Hospitals Act. If there's a rogue board, he can get it under control using the current mechanisms. Can you give us any reason why you think the minister might have been provoked to take the step he's taking in this particular piece of legislation?

Mr Shannon: I don't think it's appropriate for me to speak for the minister.

The Acting Chair: That's a good answer, because your time has just run out. Thank you very much for your deputation. We really appreciate your taking the time to come down here.

1640

GTA/905 HEALTHCARE ALLIANCE

The Acting Chair: The next presenter is the GTA/905 Healthcare Alliance; Jane Watson, chair. Welcome, Ms Watson. You have 20 minutes to use however you wish.

Ms Jane Watson: Good afternoon. My name is Jane Watson, and I am the chair of the GTA/905 Healthcare Alliance. The alliance is an amalgamation of all of the 11 hospitals in the GTA/905 area. In other words, we represent 22 sites from Oshawa to Burlington and north past Newmarket. We have been in existence for eight years, and our membership consists of the chairs and 11 CEOs of our hospitals. We meet regularly to discuss how we can work with the government to ensure the residents of our communities receive quality health care closer to home.

None of our hospitals disputes the principle of accountability. Although we're unsure of precisely why the bill was written and the specific problem it was set up to rectify or who provoked it, we certainly cannot argue with the sentiments in the preamble—no one who values the Ontario health care system could.

However, despite the good start, the original bill, particularly part III, seems to deteriorate into a series of heavy-handed demands and rigorous threats. Therefore, we were pleased to note that in his comments of February 16, the minister has admitted he believes the tone is not right in some areas, and that boards and CEOs do hold

positions of great honour and responsibility. He also promised to introduce amendments clarifying the process for entering into accountability agreements.

However, not all of the amendments or the regulations are yet available, and I must be accountable to my board, to the hospitals they represent and to the communities they serve. Hence my presence here today.

I am aware that you've already heard from numerous delegations, and you're probably tired of hearing the same message, but I beg your indulgence while I reiterate the concerns of the GTA/905 Healthcare Alliance with Bill 8 and offer some of our recommendations.

The alliance hospitals endorse the concept of a health quality council. The public and the government deserve to receive third-party information on our services and outcomes. We are confident these reports will substantiate our need for additional funding and hopefully will lead to the development of some long-term plans for meeting Ontario's health goals and commitments.

However, we do have one recommendation in this area. Section 5 should read that, "The council shall in each year deliver a report on the state of the health system in Ontario to the public and to the Legislature." In other words, the council should report to the Legislature—not the minister, as the bill currently reads. This would make the process more transparent and increase its chances of success, as it would truly be reflective of the needs and concerns of the citizens of Ontario.

With regard to health services accessibility, accessibility to health care services is one of the cornerstones of the Canada Health Act. The GTA/905 Healthcare Alliance supports efforts to ensure accessibility in the system on behalf of the 2.6 million residents in the regions of Durham, Halton, Peel and York. In reviewing the proposed legislation, the alliance has identified two key areas for consideration to ensure appropriate access to health care services.

First, although the bill has an accessibility component, we believe equitable and enhanced access to health care services requires a mechanism to ensure timely access. Patient wait times need to be appropriately measured, and patients should not be adversely affected by inherent problems in the health care system.

Second, alliance hospitals are concerned that provisions in the legislation banning payment of hospital physicians will contribute to the growing problem of recruitment and retention of key hospital positions. In a perfect world, hospitals should never have to pay directly for a doctor's services. However, in the real world there is a severe shortage of physicians. In high-growth areas such as ours, paying doctors to serve as hospitalists has been a creative solution to ensure accessibility to hospital services for people who do not have a family doctor.

Our recommendation here is that the proposed legislation needs to more closely examine measures dealing with accessibility to clearly state the government's commitment to reduce wait times and to ensure that patients receive equitable access to service, when and where they

need it. In addition, in subsection 9(2) the ban to prohibit physician payments should be eliminated.

With regard to accountability, the GTA/905 Healthcare Alliance hospitals support government efforts for increased accountability and the development of performance agreements for both hospitals and other health care providers, but we have serious concerns with how accountability measures are presented within the proposed legislation.

First, for accountability measures to be effective, they must apply to both hospitals and the government. Mutual accountability establishes a pro-active, partner-oriented system and is based on respect and recognition. We need this to establish a sustainable, effective health care system that will respond to the needs of our citizens.

Second, hospital performance agreements need to be negotiated between the government and hospitals to enable hospital boards to make the best health choices for their organizations and communities.

Third, negotiated performance agreements also encourage a collaborative relationship between the Ministry of Health and Long-Term Care and hospitals by establishing expectations, standards, performance benchmarks and the implementation of best practices, and preventing the micromanagement of the hospital system.

We believe, therefore, that the proposed legislation needs to incorporate a collaborative approach between government and health resource providers through a process of mutually negotiated hospital performance agreements, where accountability measures apply to both parties in a balanced and equitable approach. I understand that the minister has now promised that the accountability agreements will be negotiated. However, we believe this should be clearly stated in the bill, along with who exactly makes the decisions and when the decisions are to be made.

In addition, the GTA/905 Healthcare Alliance firmly supports the OHA's suggested reworking of sections 21 and 22, including its proposal for a due process for negotiation and renegotiation of accountability agreements. I know you got that information on Monday.

Just as an aside, though, I do want to caution the government that for negotiated performance agreements to succeed, the government needs to bring hospital per capita funding to appropriate and more consistent levels across the province.

I have four comments under governance.

First, the minister's enhanced role under the new proposed legislation provides sweeping powers without clarifying the minister's accountability role to both hospitals and the communities they serve. In our opinion, the existing bill will make hospitals agencies of the government and not their communities. This seems to completely contradict the goal of the current government.

Second, the minister's proposed right to direct hospital boards to sign accountability agreements without negotiations, to issue compliance directives to hospital executives and to terminate agreements essentially and fundamentally undermines the role of the hospital board.

I served as a board member of Credit Valley Hospital for 11 years, two years as chair, before I took on my current role. I joined the board because I thought I could make a difference to my community hospital on behalf of my family, friends and neighbours. I would have had no interest in joining a board that existed merely to rubber-stamp dictates from a third party.

Most board members feel the same way. During my volunteer tenure at the hospital, I interviewed numerous candidates for positions on the board. They all came with one thought in mind: to bring their expertise to help the hospital and support their community. I was often asked, "Is this a working board?" Fortunately, I could always answer, "Yes." I am not sure I could give the same answer if this bill, as it currently exists, is implemented.

Third, the existing bill also allows the minister to unilaterally alter terms of employment with hospital executives. As a person who has sat on numerous committees to select the right CEO for the hospital and the community and to choose a senior person with the right skill set to help us achieve our goals, I am personally insulted.

My work with hospitals is non-paying. In fact, it is often expensive as it can take me away from my for-pay responsibilities. Therefore, it has always been in my best interests and in the best interests of my community to choose a person who I believe can get the job done right and get it done correctly.

If I ever made the mistake of hiring someone who was inappropriate or who was unwilling to follow mutually negotiated agreements, it would be up to me to terminate their employment. I can assure you that I would not hesitate to do so. After all, their incompetence would be impacting my community. Through the alliance, I work with 10 chairs on a regular basis. My sentiments are not unique.

In addition, the bill increases the chances for the CEO to be placed in conflicting circumstances. His salary comes from one group, but tenure is impacted by another agency. Will a CEO's time then be spent walking a tight-rope trying to keep both parties happy?

Another fallout from the current bill is that hospital foundation boards may have difficulty in executing fund-raising initiatives under the shadow of the proposed legislation and the uncertainty of whether agreements may be terminated and hospital projects carried out. I think this was amply demonstrated a little earlier with the group from Southlake. In addition, local communities may be reluctant to support hospital fundraising efforts if the Ministry of Health has the power to override hospital board and executive decisions.

We also recommend that sections 23, 24 and 27 be deleted as they are unnecessary.

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Furthermore, there are a number of initiatives currently in development by the OHA and its member hospitals to provide governance and administrative support to hospitals that experience challenges in carrying out their duties. Therefore, some of the amendments I just mentioned are unnecessary.

In summary, the accountability and transparency sentiments embedded in this bill are fundamental to the quality of health care that the residents of Ontario deserve. However, sections of this act must be clarified to make it a workable document. We realize there will be amendments and regulations. We would appreciate the opportunity to come before you again to provide input in these areas.

Together, the Ontario government and its hospitals can build a health care system that would serve as a model for the rest of the world, but we have to work together.

Thank you. I'd be pleased to answer any questions you have.

The Acting Chair: Thank you, Ms Watson. There's just under nine minutes to be shared, starting with the official opposition.

Mrs Witmer: Thank you very much, Ms Watson, for your presentation. In the last point you focused on—well, I guess not quite the last—you mentioned the fund-raising. We've heard from a couple of other hospital boards that certainly if we were to take away the power, the governance structure that we presently have in place, it could have a very negative impact. We saw that recently in Cambridge, when a supervisor was imposed and there was no board. It actually did have quite a negative impact. The community wasn't quite so keen to get involved in the fundraising, and they're now hoping that will change. So I think that's a really important point and I'm glad you brought that forward, and others as well.

You've said here that you believe sections 23, 24 and 27 should be totally deleted. Could you just reiterate why you feel those should go in their entirety?

Ms Watson: Section 23 refers to the continuation of the agreement, and it brings into play people. When somebody signs on behalf of the corporation, it's the corporation that is in charge of the contract, not the person. So that part is redundant; we don't need that at all.

Section 24 is the termination clause. Again, that shouldn't come into play. It's the CEO who's responsible for the termination.

Section 27 again relates to the terms of employment of an individual. If a performance agreement is not met, the contract is with the corporation, not with the individual.

Mrs Witmer: I appreciate that. The one question I've been asking is, would you like to come back and have an opportunity to comment on the amendments to the bill, which I think at the end of the day are going to be quite overwhelming? I guess you've already indicated here that you would very much appreciate that opportunity before it goes back into the House for further debate and discussion.

Ms Watson: Definitely. The alliance hospitals want to stay within the whole process. We're in the beginning, and we want to continue right on.

Ms Martel: Thank you for being here today. Have you seen the revised framework for amendments that the minister made available to the committee?

Ms Watson: I saw it briefly when I came in the door today.

Ms Martel: That was the first time?

Ms Watson: Yes. The OHA did send out something similar, with the amendments. Again, your earlier comments in relation to the board do not seem to be addressed here. I really want to make that clear, that the CEO reports to the board and should not report to the minister.

Ms Martel: So any efforts by the minister to do a clawback on compensation or apply financial penalties or remedies as a result of non-compliance would be inappropriate for you, in your past capacity as board chair and a different capacity now?

Ms Watson: Definitely inappropriate, and I would not see why someone would want to come to a hospital and be the CEO with the idea that the minister could throw them out and take away their compensation package.

Ms Martel: Or even just trying to serve two masters, because in essence that's the position they would be put in.

Ms Watson: Definitely.

Ms Martel: You'd want to grab a copy of the document before you leave, because you would also want to take a look at some of the other sections. You reference section 27, which still says it would apply to CEOs. I think you reference sections 22 and 23. I apologize if I have that wrong. There are some suggested changes. I don't think you're going to get a whole lot of comfort once you read those. So I suggest you take that back and your boards can share that, and then you can see where we end up after March 9, when we will actually start dealing with clause-by-clause on this. I suspect this will have to come back for public hearings again, because there are so many changes that have to be made.

One question I had for you had to do with your recommendation under accessibility. You stated that the legislation needs to more closely examine measures dealing with accessibility to clearly state the government's commitment to reduced wait times. This is on your page 3. Can you give the committee some idea of what your specific suggestions are with respect to that? What is it that you would like to see in the bill around accessibility that would give you some sense that the government has some accountability back to the system and to patients as well?

Ms Watson: This is something interesting, and I'm not sure whether it would go into the act itself or more into the regulations. What I was concerned about was that in the preamble, it talks about access based on assessed need. To me, everybody in Ontario has access to the hospital system, but it may not be immediate. It could be a week, three weeks, four weeks, perhaps several hours. The preamble, which is wonderful, doesn't address the fact that it should be timely access. What we mean by timely, I don't know, but there has to be some way of figuring out how long we're prepared to let somebody wait before they have access to a doctor or to a particular procedure.

Ms Martel: Or access to cancer care treatment etc.

Ms Watson: Exactly.

Ms Wynne: Thank you for coming today. Thanks for your presentation. You said we're tired of hearing the same recommendations, but you know what? It's always interesting to get people's perspective and there's always something unique about the presentations.

I just wanted to go through some of the comments you made, and then I've got one question, OK?

Ms Watson: Certainly.

Ms Wynne: You're generally happy with the idea of a health quality council?

Ms Watson: Generally, yes.

Ms Wynne: On your issue around section 9—I know you haven't had a chance to look at the document that Ms Sourial just gave you—the proposed amendment there would amend that section to permit payments by public hospitals and mental health facilities for insured services rendered in those facilities: hospitals and laboratory physicians. I think that's what you were concerned about, and that's the direction we're going.

Ms Watson: Good.

Ms Wynne: There you go. One down.

Your concerns about sections 21 and 22: I just want to clarify that it is going to be laid out more clearly that the accountability relationship is between the minister and the board and that there will then be a performance agreement between the board and the CEO. That's certainly something that a number of hospitals have supported.

I understand that at the end of the day the concern is about the reaching over the board and dealing with the CEO—I want to come back to that—but the fundamental structure that's in place is from the ministry to the board, and then the board holds the CEO accountable.

I'm just a little worried about some of the language around the loss of authority of the local boards, because that's certainly not the intention of this bill. Right now, the minister can send a supervisor into a hospital board. That clause already exists in the Public Hospitals Act. Do you want to comment on that?

Ms Watson: There seems to be a conflict here, because the bill directly says the minister will establish an agreement with the CEO.

Ms Wynne: What I'm saying is the amendment is going to clarify that. The agreement is going to be between the board and ministry, and then there will be a performance agreement. Part of it is that we're talking about performance agreements and accountability agreements, but the accountability agreement that's envisioned in this bill is between the minister and the board. That's going to be very clearly articulated. Then what's also going to be clearly articulated—and it's referenced in our note about the amendments from Mr Smitherman—is that due process and notice and all those provisions that will be in place before the minister can take any action around the CEO are going to be laid out.

Again, there are some boards that have taken heart from that. We had a presentation today from Scarborough

Hospital, and that seemed to be moving in the direction they wanted. I'll leave that with you, but due process is part of it.

The Acting Chair: That's it for time. Ms Watson, thank you very much for joining us today.

1700

ONTARIO LONG TERM CARE ASSOCIATION

The Acting Chair: The next presenter is the Ontario Long Term Care Association, Karen Sullivan, executive director, and Nancy Cooper, director of policy and professional development. You have 20 minutes, to be used however you wish.

Ms Karen Sullivan: Good afternoon. I'm Karen Sullivan. I'm the executive director of the Ontario Long Term Care Association. With me today is Nancy Cooper, our director of policy and professional development. I'd like to thank the committee for agreeing to hear our views on Bill 8.

We're here today on behalf of our members, who operate over 400 long-term-care homes and provide care and services to over 45,000 residents throughout Ontario. Our members are a mix of private, not-for-profit, charitable and municipal organizations, in most cases with decades of hands-on experience. They have the wisdom that comes from having advocated for and adapted to significant changes in their legislative, governance and accountability frameworks.

For most of the past decade they've been attempting to meet a combination of increasing resident care needs and growing public awareness and expectations. This experience provides the context for our comments today. We hope it will help foster an understanding of our concerns and provide a learning experience.

I'd like to start by saying OLTCA supports the minister's intent to move the legislative and policy framework of our health system forward in concert with a changing environment. In so doing, however, it's important to recognize that the starting point for sectors within the health care system is different and that the legislation's impact will vary. This also means there may be lessons for all sectors in the unique experience of some, most notably long-term care.

OLTCA views this as important, in particular with respect to some of Bill 8's accountability provisions. Our association fully supports enhanced health care system accountability. OLTCA believes that not only should health care providers be accountable to the government and to those we serve but that all of these players must be accountable to each other. This fundamental principle must extend beyond simply auditing resource utilization to support a system that equally fosters effective service delivery and public confidence.

Extensive accountability frameworks are not new to the long-term-care sector. In fact, for the past decade our sector has been operating within arguably the most comprehensive accountability framework in our health

care system. Some of its elements are similar to those proposed in Bill 8.

Currently, each long-term-care provider delivers care and services under the terms of an annually renewable service agreement with the Ministry of Health and Long-Term Care. Care and service delivery standards are detailed in a program standards manual. A compliance program assesses and regulates individual home performance against these standards on an annual or more frequent basis, as deemed necessary. All compliance reports are public documents and, along with annual review reports, are required to be publicly posted.

The government has a mix of available remedies for non-compliance, ranging from graduated sanctions, such as freezing admissions, to provincial prosecutions, including licence revocation.

Long-term care is the only part of the health care system with an envelope structure for operating funding. Funding is allocated within one of three envelopes. Permitted expenditures are defined for each envelope and annually reconciled in over 100 lines of detail. The annual financial report is required to be publicly posted. If there are surpluses in care and program funding, these must be returned to the government. Also, if there are deficits, they must be made up by the provider.

All sources of funding available to providers are subject to government regulations and are capped, with the exception of charitable donations or, in the case of municipally operated homes, municipal tax subsidies.

Despite this level of comprehensiveness, this accountability framework does not meet expectations, and as an association, we have been advocating for enhancements for some time. Two of the reasons it doesn't meet expectations are relevant to the provisions of Bill 8. They can be summed up as ambiguity and inconsistency.

Let me give two brief examples that will illustrate the operational impact of accountability ambiguity and inconsistency. Our existing compliance framework includes an enforcement sanction. However, nowhere is it clearly articulated, let alone understood, what the specific conditions are that would put a home into enforcement, what the home would have to do to address the situation, how long they would have to do so, the penalties and when these penalties would apply. There is nowhere to access information on any homes in enforcement, and even if you could, it would be difficult to know what the information meant.

Similarly, providers can regale you with the uncertainty and confusion that is created by compliance standards being interpreted differently from region to region and, at times, seemingly influenced by the public issues of the day.

The lesson to be learned is that the effectiveness of compliance, enforcement and sanctions as accountability tools is related to the extent to which they are defined to create clearly understood expectations, rules and consequences, and to the extent to which they are mutually supportive. We have learned these lessons and they drive our concerns with respect to sections 19, 21, 22 and 26 of Bill 8.

While long-term care's existing service agreements strongly resemble the accountability agreement outlined in Bill 8, we are not fundamentally opposed to the basic concept of the accountability agreement as an additional accountability framework tool. We believe, however, its current broad definition creates significant risk for applications of this tool with respect to setting goals, objectives, time frames and requirements that are either inconsistent or conflict with the existing service agreements and the program standards manual.

The potential risk for these inconsistencies and conflicts is exacerbated with Bill 8's use of directive wording with respect to providers signing accountability agreements. This prescription is in contravention of the fundamental tenet of contract law, which stipulates that parties must enter into a contract freely. This tenet applies to the existing service agreements. Further, since this legislation does not place any accountability on government to fund the system appropriately, the current wording would leave an open door for government to create arbitrary and unachievable expectations and goals.

We strongly urge this committee to amend the legislation to ensure that the scope and application of accountability agreements is specifically defined and consistent with existing long-term care service agreements and other accountability instruments and that accountability agreements are negotiated, not directed.

Section 22 gives the minister very broad power to issue directives "compelling a health resource provider ... to take ... action specified in the directive or to comply with one or more of the prescribed compliance measures." This gives us cause for concern at two levels, given that providers can only do what the government is willing to fund and that funding will always be limited.

Our first concern relates to the fact that providers are required to deliver the program that is encompassed by the governing legislation, the service agreement, the program standards manual and the funding provided by the Ministry of Health and Long-Term Care. There is nothing in this current wording of Bill 8, however, to prevent the minister from arbitrarily directing compliance outside these defined and funded program parameters. In such instances, providers would be left with the option to either not comply with the minister's directive or to potentially violate the existing service agreement. This would likely have a further negative impact by directing scarce care resources away from where they are already sorely needed.

Our second concern is that a resulting compliance directive might be seen to be within existing program and funding parameters when in fact it is not. For example, ministry compliance advisers have already been recommending one-to-one programming for the growing number of residents affected by dementia. I don't know of an operator, an administrator, a director of care or any other staff member who would disagree with this recommendation. This level of care, however, cannot be provided within current funding levels. A minister's directive would leave two choices: to not comply or to

take the care resources from one person to another. Neither is appropriate, palatable or defensible.

In view of this, we urge this committee to amend the wording of section 22 so that it confers powers consistent with the mandated scope and available resources of the long-term-care program. The fundamental principle should be that providers are accountable for delivering the defined and funded long-term-care program. The minister's powers to direct should be clearly specified and understood to operate consistent with this principle.

For the same reasons, we make a similar recommendation for section 26, which sets out "consequences of failure." The minister's scope for action should be specifically defined, understood and consistent with the provisions of the service agreement and other existing accountability instruments.

Based on the day-to-day experiences of our members, OLTCA believes that without measures to clarify these ambiguities and remove the risk for inconsistency in application, Bill 8 will not support resolving the current accountability issues in long-term care. It will also increase the risks that these same issues will appear elsewhere in other sectors of the health care system.

Before leaving accountability, I wish to note for the committee three other areas of concern to our association.

The first is the non-liability clause in section 30. Typically, the non-liability clause in a bill would provide that no action can be taken if the minister has executed the authority provided under the legislation in good faith. This good-faith principle is not specified in the non-liability clause in Bill 8. In view of the fact that Bill 8, as it is currently written, conveys broad powers to the minister and the fact that all health care providers and those the system serves have the right to expect that the minister does indeed act in good faith, we believe the good-faith principle should be specified.

Our second concern deals with the penalty provisions set out in section 31. We agree with others who have pointed out that these are unduly harsh and unnecessarily punitive.

1710

Our third concern is that Bill 8 is silent on its application to our municipal homes for the aged and our charitable homes. As members of this committee may or may not be aware, municipal homes for the aged are operated by municipalities and, as such, are subject to municipal legislation. Similarly, charitable homes are operated by volunteer community-based organizations and boards. We would request that the relationship of Bill 8 to these types of governance structures be further clarified.

We now turn our remarks briefly to part I of Bill 8, dealing with the Ontario Health Quality Council.

OLTCA fully supports measures to enhance service quality, and we believe this council has some potential to do this. However, we recommend the following changes to Bill 8 to increase the likelihood for this potential to materialize for long-term care.

First, it is essential, given the increasing importance of long-term-care services to Ontarians, that long-term-care

resident issues be recognized and valued in the appointment of council members. Currently there is reference to choosing “experts in ... areas of patient and consumer issues,” but no reference to residents. We strongly urge this committee to correct this oversight.

Secondly, we urge that the term “health system organization” be expressly defined as it relates to those who are prohibited from sitting as members of the council. We assume this prohibition is meant to avoid a perception of bias in the council’s conduct of its business. If we are correct, then the definition of “organization” must be sufficiently broad to encompass the full range of organizations that inhabit the health care field: providers, professionals and consumers alike.

Thirdly, we believe that an effective focus on quality, which by definition requires long-term stability, will only be accomplished if the “specific powers and duties of the council and its members” are set out clearly in the legislation and are not left to the uncertainties of cabinet regulation.

Finally, we are concerned that it is not clear how this new council would interact with the other individuals and agencies that are currently authorized to inspect or audit long-term-care homes. Our concern is not with the concept of audit or inspection. We are left to wonder, however, about the additional management and administrative resources that might be required when homes are already strapped for resources to deliver an increasingly higher level of care.

In closing, I want to again thank the committee for giving us the opportunity to share our experiences and our concerns. Bill 8 is an important piece of legislation that will impact the lives of Ontarians in a significant way. It is important that its provisions be drafted so its goals can be achieved within the reality of where health care is provided and received.

The Acting Chair: There are about six minutes left to be divided evenly. Ms Martel.

Ms Martel: Thank you for your presentation today. May I ask what discussions on this bill you might be involved in with the ministry right now? Any?

Ms Sullivan: Not on this specific bill, except for coming here.

Ms Martel: Can I ask when you first saw the bill? Was it at the time it was introduced, November 27 or so?

Ms Sullivan: Yes.

Ms Martel: The reason I ask that is that it’s very clear that long-term-care facilities are to be the subject of the accountability agreements. We have certainly heard there have been ongoing discussions between OHA, OMA and other providers, but it’s interesting that there’s no discussion going on directly with you right now, because you represent a significant number of facilities that are going to be directly affected. Essentially, your first presentation about your concerns is to this committee right now.

Ms Sullivan: That is correct.

Ms Martel: I’m sure the ministry is going to take that into account and start to have some discussions with you

directly, because there are a number of very specific concerns you raise that clearly show that how you operate now under the service agreements would not be compatible with accountability agreements per se. It’s also not clear to me whether the government can achieve what it wants through the current service agreement structure or whether an additional layer of bureaucracy is going to be added over and above the agreements.

Ms Sullivan: That’s the main part of our concern. We, unlike other parts of the health care system, have had service agreements and different forms of accountability than others. We accept that. We look after the frailest people in our society, and we get government dollars to do that, and so we think it’s really important that we’re accountable. There’s just some confusion around how those will work with this. Certainly, the entire issue of accountability in long-term care is being looked at, so we want to make sure it all meshes and works and doesn’t make more ambiguity or inconsistency, which is part of the issue around the current pieces of accountability we have.

The Acting Chair: Ms Smith.

Ms Smith: It’s good to see you again. I appreciate your taking the time to come out and provide us with your input on this. I think I’m more familiar with the workings of long-term care than some members on this committee, or I’m becoming more familiar. So I appreciate a lot of what you’ve put together today.

One question I have for you is a very specific question on the service agreements that are annually renewed. What are the provisions in place if you don’t come to an agreement with the ministry on a service agreement?

Ms Sullivan: We have an evergreen clause, because they don’t always arrive for us to sign within the time frame they apply to. They don’t automatically expire; there is an evergreen clause until we get the next one.

Certainly since 1993 there has been full compliance. In the early days, when the service agreement was first developed, it took some time for the sector to understand what it meant, and there was some back and forth on the development of the agreement. But I don’t think—and I don’t know this for sure—you’d find a home that doesn’t have a signed service agreement.

Ms Smith: You spoke about your concerns about ambiguity and inconsistency, and one of the things you raised was enforcement sanctions in the long-term-care framework. The minister presented to this committee last week a framework for the amendments we see coming out in the next short while with respect to this legislation. Did you have a chance to see those?

Ms Sullivan: I looked at them but very briefly. Actually, I saw them today for the first time.

Ms Smith: One of the things we’re looking at, with respect to accountability agreements and compliance directives, is to “Include notice and other due process provisions, including time frames for notice, to address development of accountability agreements, issuance of compliance directives and orders (eg, discussion process, meetings, exchange of documents/information, represen-

tations that the minister has to consider before issuing a compliance directive or an order.)"

Would those kinds of mechanisms go some way to easing your concerns about ambiguity in the process?

Ms Sullivan: Yes, they would help.

The Acting Chair: Mrs Witmer.

Mrs Witmer: Thank you very much, Ms Sullivan. I'm glad we have finally heard from the long-term-care sector, because obviously you do come under the jurisdiction of this bill. I would hope, having heard that you haven't had any consultation with the Ministry of Health until now, that there would be an opportunity for you to engage in some discussions, because I think there are some unique issues you have with this bill that others may not.

I'm also glad that you took the time to remind this committee, because I think there are some people who maybe forget, that there are already accountability frameworks in place. It's not something new. It's certainly something that has been ongoing. You've also pointed out some of the drawbacks of those accountability agreements. I think that's important, because if there are problems such as ambiguity and inconsistency now, it really does speak to the fact that the government needs to consult with stakeholders to ensure that some of the problems you've experienced are going to be dealt with before any future accountability agreements are put in place.

I think you make a very good point about the fact that in section 22, with the minister having broad powers to issue directives compelling a health resource provider to take action, there is cause for concern, because ob-

viously, at the end of the day, you can only do what you're able to do based on the funding you receive. I think it's important, and maybe is being forgotten, that obviously our health providers try to do the best job they possibly can. But there are scarce resources, and you can't be found at fault if you don't have the resources to do your job.

Do you think this whole issue of funding could have some serious implications as the government moves forward with these accountability agreements?

Ms Sullivan: The whole notion of accountability for our sector is about a partnership around that accountability. We want to deliver the best possible care to people's parents and grandparents, and we want to be able to demonstrate that we're doing that. If we're not, we think there should be things you can do to remedy that, because it's a serious issue.

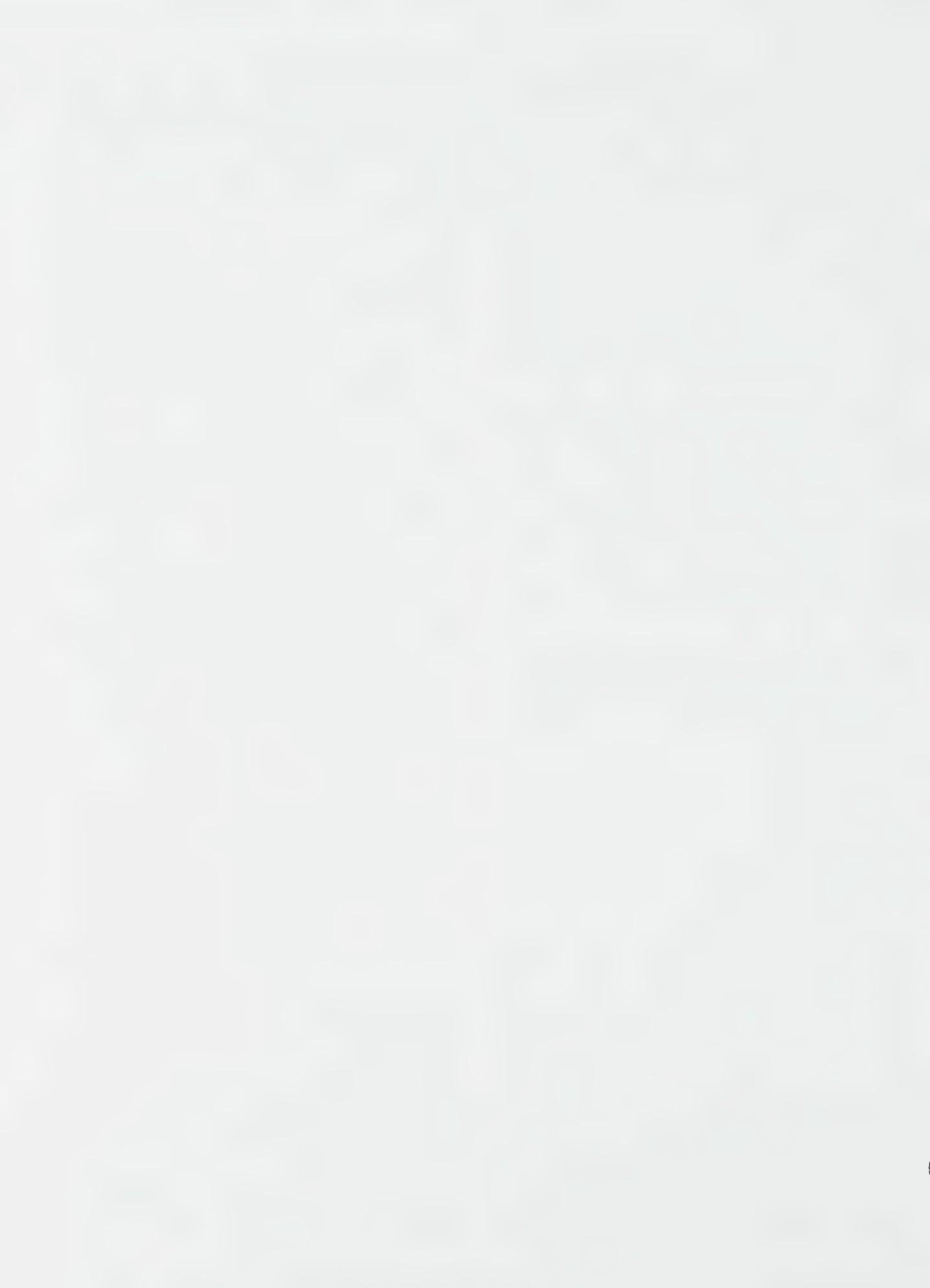
But a part of it certainly is that we have to do that within the framework that exists. The framework is accountability and it's funding. Our funding comes from two sources. It comes from the government and it comes from the resident, but both portions are defined by the government.

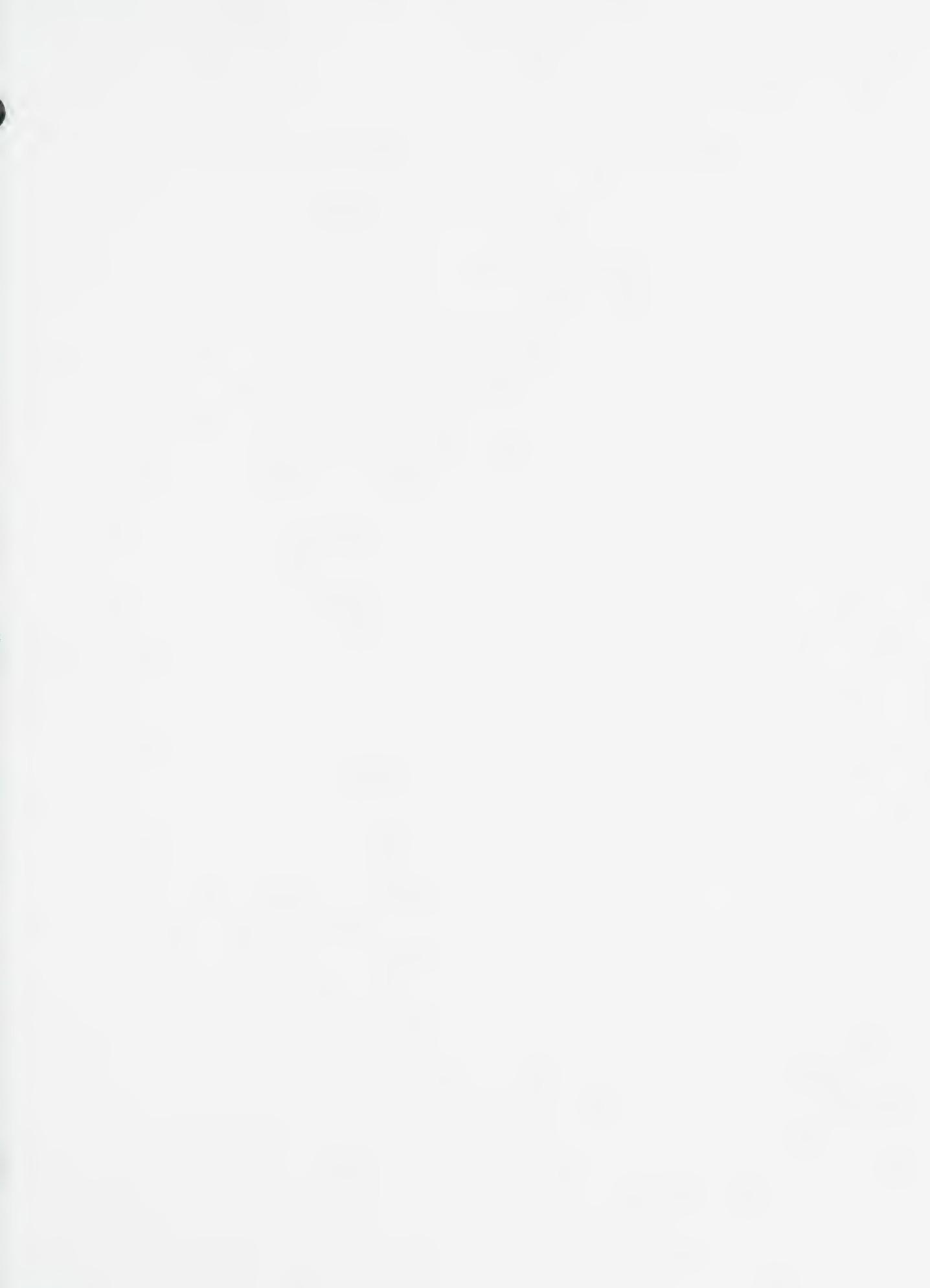
So that was our statement around accountability being all the partners. It has to be that kind of relationship.

The Acting Chair: Thank you very much. We really appreciate you coming here, making a deputation and taking the time.

The committee now stands adjourned until tomorrow morning in Niagara Falls.

The committee adjourned at 1721.







STANDING COMMITTEE ON JUSTICE AND SOCIAL POLICY

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Legislative Assembly of Ontario

First Session, 38th Parliament

Official Report of Debates (Hansard)

Thursday 26 February 2004

Standing committee on
justice and social policy

Commitment to the Future
of Medicare Act, 2003

Chair: Kevin Daniel Flynn
Clerk: Susan Sourial

Assemblée législative de l'Ontario

Première session, 38^e législature

Journal des débats (Hansard)

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Comité permanent de la
justice et des affaires sociales

Loi de 2003 sur l'engagement
d'assurer l'avenir
de l'assurance-santé



Président : Kevin Daniel Flynn
Greffière : Susan Sourial

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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON
JUSTICE AND SOCIAL POLICY

Thursday 26 February 2004

The committee met at 1001 in the Best Western Cairn Croft Hotel, Niagara Falls.

COMMITMENT TO THE FUTURE
OF MEDICARE ACT, 2003LOI DE 2003 SUR L'ENGAGEMENT
D'ASSURER L'AVENIR
DE L'ASSURANCE-SANTÉ

Consideration of Bill 8, An Act to establish the Ontario Health Quality Council, to enact new legislation concerning health service accessibility and repeal the Health Care Accessibility Act, to provide for accountability in the health service sector, and to amend the Health Insurance Act / Projet de loi 8, Loi créant le Conseil ontarien de la qualité des services de santé, édictant une nouvelle loi relative à l'accessibilité aux services de santé et abrogeant la Loi sur l'accessibilité aux services de santé, prévoyant l'imputabilité du secteur des services de santé et modifiant la Loi sur l'assurance-santé.

ONTARIO NURSES' ASSOCIATION,
NIAGARA REGION

The Chair (Mr Kevin Daniel Flynn): Ladies and gentlemen, I call the committee to order.

The first delegation this morning is from the Ontario Nurses' Association, Niagara region. Jo Anne Shannon is with us from local 26.

I'll just explain the rules, Ms Shannon. You have 20 minutes, and you can use that 20 minutes any way you see fit. At the end of your presentation, if there is any time left, we will try to split that evenly among the three parties that are present here today with some degree of fairness. The floor is yours.

Ms Jo Anne Shannon: Good morning. My name is Jo Anne Shannon, and I'm a registered nurse working in the ICU of the Greater Niagara General site of the Niagara Health System. I am the bargaining unit president for the Niagara Health System and local coordinator for local 26 of the Ontario Nurses' Association. In that capacity, I represent 1,500 hospital nurses from Niagara, including the Niagara Health System and Hotel Dieu Health Sciences Hospital. I'm pleased to have this opportunity today to provide ONA's perspective to the standing

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

COMITÉ PERMANENT DE LA JUSTICE
ET DES AFFAIRES SOCIALES

Jeudi 26 février 2004

committee on justice and social policy regarding Bill 8, the Commitment to the Future of Medicare Act, 2003.

First let me tell you more about who ONA represents. As you may be aware, ONA is the union that represents more than 48,000 registered nurses and allied health professionals working in hospitals, long-term-care facilities, public health, community agencies and industry throughout Ontario. ONA's primary responsibility is to safeguard the professional interests of our members. It is also the professional obligation of ONA to speak out on behalf of the public good and our patients.

At the same time, the public puts a great deal of faith in nurses, as indicated by numerous polls. This year, 95% of 1,500 respondents in one survey said they trusted nurses most, just slightly below firefighters.

Canadians have clearly indicated they share the same commitment as nurses to the preservation of our public medicare system. With this in mind, I'd like to talk to you about our concerns regarding the impact of Bill 8 on the future of medicare in Ontario.

During the recent Ontario election, the provincial government made a number of commitments regarding medicare. On introducing Bill 8 for first reading in November, it was heartening to hear Minister George Smitherman comment that Ontarians want to see "progress and real, positive change in health care versus more creeping privatization of health delivery." He also talked about the Liberal government building a health care system that is public, universal and accountable—extremely encouraging words for Ontario's nursing community. We fully intend to hold the government to this standard.

ONA believes one of the gravest issues facing our public health care system today is the chronic nursing shortage, which grows with each passing day. Just like their commitments to medicare, the Liberals made a commitment to hire nurses. To quote directly from their campaign literature, the Liberals told Ontarians, "We will hire 8,000 new nurses." While the government may have good intentions, we have yet to see concrete delivery on this promise.

By December 31, 2005, when the Hospitals of Ontario Pension Plan bridge benefit expires, 15,000 of Ontario's registered nurses will be eligible to retire. Within the Niagara Health System alone, 22%, or over 250, of our hospital nurses will be eligible to retire by that date. By 2008, if Ontario's nurses choose to leave at age 55, we could lose more than 30,000 nurses.

The 8,000 new nurses are desperately needed now. This issue must receive the necessary priority before Ontario's hospitals are forced on a widespread basis to involuntarily close hospital beds because there are not enough nurses to care for the patients. The nursing shortage must receive the necessary priority. This bill is not going to help Ontario deal with the current nursing shortage.

The health minister did announce a small first step on February 24: \$50 million in funding for hospitals is to be targeted to increase full-time nursing positions and to improve the safety and working conditions of our nurses. But details are unknown and many questions remain unanswered.

The same goes for Bill 8 and medicare. We don't see the government acting on the specific commitments to protect and expand medicare outlined in the preamble to the legislation. Nurses support our public health care system. We want our patients to be able to rely on it. However, Bill 8 doesn't provide that guarantee, nor does it lay out a vision for rebuilding and restoring confidence in our public system.

During his February 16 presentation to this standing committee, Minister Smitherman admitted Bill 8 needed changes and later tabled a draft framework for amendments. While the draft framework provides some specifics, without actual wording it doesn't cover other concerns we intend to raise. Yet here we are today commenting on a bill that we know will change. This process is simply unacceptable to nurses. So ONA joins with the chorus of voices calling for the minister to table all of his specific amendments. Failing that, we urge the government to bring the amended legislation back to this standing committee following second reading for a detailed review.

The preamble to Bill 8 provides the government's vision for medicare in Ontario, confirming its commitment to medicare and the principles of the Canada Health Act: public administration, comprehensiveness, universality, portability and accessibility. It acknowledges, as did the Romanow commission's report, that primary health care, pharmacare and home care are vital to the future of medicare. It recognizes the importance of the principle of public accountability, which we interpret to mean accountability to the public. ONA supports this vision. Yet the health minister's public actions do not support the vision of medicare portrayed in the preamble.

In his remarks to the Legislature on introducing Bill 8, Minister Smitherman said, "Our new government has acted to ensure new hospitals in Brampton and Ottawa are publicly owned, publicly controlled and publicly accountable." To date, however, these negotiated deals have not been released to the public. This is not being publicly accountable. Indeed, when the deals are finally released, they will be final deals and not open to any public input process.

This secretive negotiations process, ostensibly in the name of protecting commercial confidentiality and competition, is the same rationale used to keep from the

public domain contracts that are signed with for-profit home care providers under the managed competition system for bidding on home care contracts. This deplorable system that puts price before quality patient care remains intact under the Liberal government, plain and simple. It stands to reason that if making a profit is the goal, service will be rushed, rationed or reduced, and when that happens, patients suffer. These are some of the most vulnerable people in our society, including frail elderly and early discharges from hospitals, many of whom now require more complex care than ever before. This is not being publicly accountable.

Further, Minister Smitherman says the government "will soon move to ensure that private MRI and CT scan clinics ... are returned where they belong: to the public domain." That was in November, and this is March. We are still waiting for the minister to be publicly accountable.

Bill 8 could have been a great opportunity for the minister to put public uncertainty to rest and declare that there would be no expanded privatization of our public health care system, that further public-private partnerships involving our hospitals would be prohibited and that paying for private services such as medically unnecessary scans at private clinics would also be prohibited. We urge the committee to amend Bill 8 to clarify that further privatization of our public system is expressly prohibited.

Let me now talk more specifically about the model of accountability in Bill 8. The minister has said that all accountability agreements will be disclosed to the public. We also take this to mean that amendments will be made to section 29 to make it clear that all parts of any accountability agreements, compliance directions and any orders will be publicly disclosed. Accountability must include transparency, and this must not be left to the minister's discretion.

ONA believes that part III of Bill 8 introduces provisions that have the potential to undercut the provisions of a collective agreement. Obviously, this causes great concern to our members working in the health care sector. The language in Bill 8 is very broad and general and does not stop the government from prescribing unions as entities that may have to enter into an accountability agreement. In addition, the language used in defining the scope of an accountability agreement and the scope of the minister's discretion to issue directives is broad enough to encompass matters that touch upon collectively bargained rights. The minister's power to make orders for failure to enter into or comply with an accountability agreement or directive is also framed very broadly. The most significant details regarding the accountability measures and the minister's powers are left to be prescribed in regulations.

The minister has now indicated that solo physicians, group practices and trade unions are not considered health resource providers for the purposes of the legislation and as such would not be required to enter into accountability agreements nor be subject to any provisions of part III.

Hospitals, long-term-care facilities, community care access centres and independent health facilities would be subject to accountability agreements. We seek a further clarification from the standing committee as to whether home care providers are included as part of community care access centres.

In order to be crystal clear regarding the potential impacts on trade unions, we believe the amendment should delete the reference in subsection 21(1) that allows “any other prescribed person, agency or entity,” through regulation, to be subject to accountability agreements. We also take the minister at his word that Bill 8 is not intended to impose additional accountability requirements on individual health care professionals, but that they would continue to be held accountable for their conduct through their professional colleges.

Let me now discuss other concerns we have with respect to part III. Bill 8 gives the government the power to create accountability agreements covering a wide range of issues. What may form part of an accountability agreement is defined very broadly in section 19. The definition is framed in such general language that it provides little real insight into the content or limits of an accountability agreement. Particularly in light of paragraph (d), an accountability agreement may touch on any matter that may be prescribed by the government. This does not provide our members with a great deal of confidence that accountability agreements could be prescribed to cover areas that would have a direct impact on their working lives.

1010

The minister indicated in his remarks to the standing committee that accountability agreements will be negotiated. Independence of governance structure—for example, executive board—will be maintained by requiring accountability agreements between the ministry and the health resource provider. The details of how this will work and who is able to make representations remain unclear.

This proposed amendment provides our members with more assurance that accountability agreements will not be imposed. However, we don't see the role for community involvement that the minister is willing to include in the preamble.

We are concerned about the ultimate scope of accountability agreements. Section 20 of Bill 8 sets out principles that the minister is to consider in administering all of the accountability measures in part III. However, this section does not impose any clearer limits on what may be included in any such agreement.

Some items, such as number 6, “value for money,” cause us grave concern, since that term generally has been used most recently in the context of privatization initiatives in hospitals such as public-private partnerships. This is very worrisome to us.

Section 20 sets out that in administering part III of Bill 8, “the minister shall be governed by the principle that accountability is fundamental to a sound health system....” In administering part III, the minister is also

required to consider the importance of the 12 matters identified “that the minister, in his or her discretion, determines to be appropriate in the circumstances.”

Again, the factors to be considered by the minister are very broad. As a result, the minister has extremely wide discretionary powers to determine what may form the substance of any accountability agreement, even though such agreements are subject to negotiations between the ministry and the board of the health resource provider. The language in section 20 is certainly broad enough that an accountability agreement could encompass matters that touch upon collectively bargained rights.

It is for this reason that we urge the standing committee to consider an amendment that expressly precludes the minister from negotiating accountability agreements that would in any way override collective agreement rights and would prevent the ability to interfere with these rights.

Again, the minister has clarified in his draft framework that section 27 would only apply to CEOs, not trade unions or other employees, who are subject to an order under section 26. However, sections 22 and 24 in Bill 8 give the minister sweeping powers to issue directives to health resource providers or any other prescribed person.

The minister's ability to issue compliance directives is stated in the broadest possible language once again. What specific compliance measures may be prescribed are unknown until the regulations are drafted. On the existing language, it may be possible for the minister to issue directives or orders that affect collectively bargained rights.

Our final concern relates to what measures the minister may take where there is a failure to enter or comply with an accountability agreement or comply with a ministerial directive. The minister's power to make orders in relation to these failures to comply are set out in sections 26 to 28 of Bill 8. Once again, it is not possible to determine what nature of orders the minister may make under section 26, as the measures that may be ordered will be prescribed in regulations.

We therefore are seeking a further amendment to clarify that the minister's powers are not intended to be used to undercut collective bargaining. We note in particular that where a health resource provider's “funding is reduced, varied or discontinued” as a result of an order under Section 28, this could clearly have an impact on our employees and our members.

Part I of Bill 8 provides for the establishment of the Ontario Health Quality Council. While we support in principle the formation of an Ontario Health Quality Council, we question the value to Ontarians of a council that is restricted in function to monitoring and reporting on issues related only to quality and access.

We believe the council should be reporting on how Ontario's health care system measures up to the principles contained in the Canada Health Act. In our view, the council should have the ability to report on all parts of Ontario's medicare system as they relate to these principles.

Equally perplexing, the council has the power to report but not to issue recommendations. In subsection 5(4), the council is prohibited from making recommendations to the minister, except as it relates "to future areas of reporting."

This is even more disconcerting when we consider that clause 5(3)(b) lays out that one of the purposes of the council's reporting function is to "make the Ontario health system more transparent and accountable." We don't see how that purpose can be accomplished without the council having the statutory power to make recommendations rather than just reporting on access and quality.

A further concern is that details relating to the budget, operations and full powers of the council remain to be prescribed by regulation. We support a more inclusive process for the appointment of council members. Our preference is to have council members appointed through an all-party process or by a standing committee of the Legislature.

In addition, we support an amendment expressly stating the council will consult with and seek public and stakeholder input in the course of their duties. The council must be able to access the information it needs to meet its mandate. This process would carry added legitimacy to recommendations flowing from the council, if the standing committee adopts our amendment to permit the council to issue recommendations on what needs to be done to ensure the future of medicare in Ontario.

Part II in Bill 8 confirms the section 9 prohibition of physicians or designated practitioners from charging or accepting payment for more than OHIP pays for an insured service. We are concerned that clause 9(4)(b) does not close the door firmly on extra billing but may allow extra billing to be prescribed by regulation.

Section 15 confirms the existing prohibition against jumping the queue by paying extra for insured services.

Bill 8 does introduce two new changes regarding fees. Section 33 amends section 15 of the Health Insurance Act by prohibiting physicians and designated practitioners from opting out of the provisions of OHIP and receiving payment for insured services directly from patients. We support this change.

We also support the prohibition against block or annual fees in section 16 of Bill 8. Block fees for uninsured services, such as prescription renewal by phone, have become more common. Indeed, companies have been set up to manage block fee payments for physician practices.

We are concerned that subsection 16(1) does not fully ban block fees but allows for block fees to be charged if provided for by regulation. We support a full legislative ban on block fees. Patients must know the full cost of every uninsured service and must be able to pay for such uninsured services as they are used and not on an annual basis, paid in advance.

Registered nurses have long held that essential health care services should be delivered through publicly owned and not-for-profit organizations under the guiding prin-

ciples of the Canada Health Act. The proliferation of private, for-profit delivery of health care services is a threat to medicare and must be stopped.

Our members believe that Bill 8 does not protect the future of medicare in Ontario. We urge the standing committee to adopt the amendments that we have put forth so that future generations may enjoy what we take for granted today: public medicare.

Relying on intention is not enough to guarantee that future. We ask that Bill 8 include specific prohibitions, as outlined. The future of medicare is too vital to our health and well-being to be left to good intentions.

Health care is a public service and a not-for-profit service. Nurses will vigorously oppose any legislation that results in the proliferation of privatization in health care in Ontario. Our vision is for an integrated health system that is publicly owned, funded and delivered, and accountable under the Canada Health Act.

We believe the Canada Health Act must be expanded to include home care, long-term care, pharmacare and reorganized primary health care. We don't believe Bill 8, as currently written, provides a firm foundation to build this future.

On behalf of the members of the Ontario Nurses' Association, I'd like to thank you for listening to this presentation. I would be pleased to answer any questions.

The Chair: Thank you, Ms Shannon. You've used up almost 18 minutes, so we're going to start with the opposition parties for two minutes. Maybe we'll have just one question this time.

Mr Tim Hudak (Erie-Lincoln): Ms Shannon, good seeing you again. You made an outstanding presentation. The only people who actually like this bill are the printers. There are going to be so many amendments for so many weeks to try to correct every mistake in this bill. Your presentation comprehensively outlined about seven or eight major problems with this bill. I don't have time to go into all of them.

What I wanted to concentrate on is the Ontario Health Quality Council. You point out that it actually has very little power to make any kind of recommendations to the system, that it's basically controlled by the minister, appointed by the minister and reports only to him. One suggestion that we're looking at is to make the health council come to the Legislative Assembly, to actually bring the report to the assembly as a whole, to the MPPs, just like what's happening with the Auditor General in Ottawa. Instead of hiding it with the minister, it would become public.

How would you feel about an amendment to make sure that the Ontario Health Quality Council reports to the assembly, as opposed to directly to the health minister?

Ms Shannon: I really can't comment on behalf of ONA on that amendment, but we definitely want it to be publicly accountable.

Mr Hudak: And the release should be to the public as a whole, as opposed to just going to the minister at his discretion for a release?

Ms Shannon: The most important part is that it actually has the ability to make recommendations.

Mr Hudak: Publicly.

Ms Shannon: That is the biggest problem that we see with it.

The Chair: There is still a minute remaining. Mr Kormos, would you like to use that?

Mr Peter Kormos (Niagara Centre): Just as we applaud the role of Ms Fraser up in Ottawa, we've called upon her to do an audit of the \$5 million-plus that was paid out to Tory cronies, to Ontario Power Generation.

Thank you very much for coming, because I was here on the opening day, and the government was saying all these critics of this bill are all full of hot air, that everybody's wrong and they're right, even on the issue of queue-jumping. Just this morning, I'm driving down the QEW in my 10-year-old pickup truck and I'm listening to the radio. I've got the OMA telling the parliamentary assistant that basically she doesn't know what she's talking about when it comes to queue-jumping. Maybe legislative research could help us resolve this issue. Is queue-jumping a phantom, faux, a straw man as such, or is it a real phenomenon? Who is right, Ms Smith or the Ontario Medical Association? Neither of them is in my camp, so you can't accuse me of being anything other than impartial.

1020

The Chair: Thank you, Mr Kormos. Mr Craitor.

Mr Kim Craitor (Niagara Falls): First of all, thank you very much for coming out, Jo Anne. You and Kim were in my office a week or two ago, and I said to both of you that I thought it was extremely significant that you be here and that the committee hear your comments.

Just a couple of very quick things. First of all, there are some things I have learned as a new MPP. For example, previous governments, for whatever reason, didn't have these types of hearings after the bill left the House for the first time.

Mr Hudak: It's not true, Kim. You know that's not true.

The Chair: Order, please. I think we listened to you. You'll have your chance.

Mr Craitor: Obviously, the truth hurts sometimes.

The point I was making to you, Jo Anne, was simply that I felt it was significant for the committee to hear the comments you made to me and some of the concerns you expressed to me, even in my office. I do remember some situations, even with my local hospital here, when I stood in a room with you and the nurses, upset again with the previous government for some of the things they were doing to destroy our hospitals.

I just wanted to say thank you very much. There will be a number of amendments. There have been some put forward, but I know there will be some others, because of the input we're receiving from organizations like yours.

The Chair: Thank you, Ms Shannon. We appreciate your coming this morning.

WEST HALDIMAND GENERAL HOSPITAL

The Chair: We're going to move on to our 10:20 delegation, which is from the West Haldimand General Hospital. Parry Barnhart, the vice-chairman, is with us this morning. Sir, you've got 20 minutes to use any way you see fit. If there is any time left over at the end of the presentation, we will ask you questions on a rotational basis. This time, the rotation would start with Mr Kormos.

Mr Perry Barnhart: Good morning, Mr Chairman and committee members. I am pleased to be here today before you to provide our comments and concerns with respect to Bill 8, the Commitment to the Future of Medicare Act, 2003.

My name is Perry Barnhart. I have served as a hospital trustee for the last 18 years. I have served as treasurer, vice-chair, chair, past chair and board secretary of the Haldimand War Memorial Hospital in Dunnville. Today I am here in my volunteer role as vice-chair of the board of governors of the West Haldimand General Hospital.

The West Haldimand General Hospital opened in 1964 and originally had 90 beds. The hospital now has 33 beds and provides acute and medical care, chronic care, 24-hour emergency services, primary health care services, a total of 10 other shared services with community partners, 13 specialist clinics and several health promotion programs. The hospital has been accredited for many years, and just recently it was successful again in receiving full accreditation. The hospital has a very strong auxiliary and an organized foundation. The hospital is located in network 4, with two other network partners, the Hamilton Health Sciences Corp and Haldimand War Memorial Hospital in Dunnville.

I might point out that the West Haldimand General Hospital's board of governors is supportive of legislation to establish the Ontario Health Quality Council and to enact new legislation concerning health services accessibility and to provide continuity in the health care sector. We appreciate the opportunity to be here today. I would like to state that the West Haldimand General Hospital supports the government's commitment to medicare and key aspects of Bill 8, including the adoption of the five key principles of the Canada Health Act and the inclusion of accountability as a sixth principle. However, we are very concerned, given the way the bill is drafted, that this legislation will have opposite effects and fundamentally undermine medicine in Ontario.

Regarding part I, the Ontario Health Quality Council, Bill 8 specifically prohibits board members and senior staff members of a health system organization from being members of the council. We do note that other organizations that represent physicians and nurses and other professional groups appear to be eligible for appointment to the council.

Further, it is unclear who is captured under the definition of a "senior staff member of a health system organization." We have raised the above issues because we believe it is important to ensure that the hospital

sector boards and administration perspectives are appropriately represented on the council or, in the alternative, that the principles that were considered in excluding hospital board members and senior staff members from council equally apply to the health system's other stakeholders that provide health care services or other major parties involved in the health care industry. We seek clarification of these issues and a reasonable balance of representation on the council.

Further, we are concerned that the proposed legislation should empower the council to make recommendations to the minister, including recommendations with respect to the minister's or ministry's responsibilities.

Finally, we believe that consideration should be given to putting in place a mechanism to ensure the independence of the members appointed to council. We want to ensure that any council reporting to the Legislature is not unduly influenced.

With respect to part II, accessibility, the board does have some concerns with respect to some aspects of the legislation. It appears, for example, that Bill 8 will prohibit hospitals from paying monies to hospitalists or physicians providing on-call services. I might advise that our hospital records indicate that over 60% of in-patient admissions are patients who do not have a family physician on staff. Therefore, the in-patient care for these patients is provided by physicians who are on staff. While the ministry has provided some funding—hospital on-call coverage, or HOCC, monies—the hospital does provide additional recoveries to physicians to ensure the continuation of in-patient care for these patients.

While it is not a serious issue for our hospital, it would appear to be a serious issue for many hospitals across the province. We do suggest, however, that any payments or fees paid to physicians to provide services to the hospitals across the province should be negotiated between the Ministry of Health and the Ontario Medical Association in their regular reviews of compensation, and that these negotiations be consistent across the province and included in the OHIP schedule of fees.

With respect to section 15, we note that Bill 8 prohibits a person or an entity from charging or accepting a payment or a benefit for conferring upon an insured person their preference in obtaining access to an insured service. This prohibition, together with the mandatory reporting provisions of Bill 8, and the sizable penalty set out in section 17 may create some difficulty to ensure that all employees and physicians adhere to section 15.

You will note that subsection (2) prevails. There is an obligation of reporting information. It is applicable even if the information reported is otherwise confidential or privileged. We suggest to the committee that a further review of section 15 and clarity with respect to some of the sections would be useful, particularly with respect to mandatory reporting and penalties for individuals and the corporation.

As to part III, accountability, we believe that rather than setting up a system of accountability in the health care sector, as the title suggests, part III of Bill 8 seeks to

tighten the reins of the ministry over health resource providers, which includes hospitals. We believe the accountability measures undermine community involvement and the local voluntary governance of all hospitals in Ontario.

In particular, sections of part III provide the minister with the right to (a) require hospitals and hospital executives to enter into accountability agreements, (b) issue compliance directives to hospitals and hospital executives, and (c) unilaterally alter hospital executives' terms of employment. We suggest this fundamentally undermines the relationship between the CEO and the board and, in doing so, also calls into question the fundamental role of the board as the governing body of the hospital. The fundamental issue is the potential erosion of local volunteer governance that now ensures that our local community has a voice in accessing hospital services.

I'll now record our concerns regarding community involvement and governance. We suggest that Bill 8 undermines local voluntary governance of our hospital in two basic ways. First, by directing hospital boards to sign accountability agreements without negotiation or agreement, the government is removing an important check and balance in communities throughout Ontario, and particularly in our small rural hospitals. Second, by having the power to make an order affecting the employee of the hospital, the government is again usurping the role of the board in section 26 and 27. As a result of these changes, our community will no longer have a say in the hospital services they receive and how their local hospitals are managed.

1030

Unilaterally imposing agreements undermines governance and negates the Public Hospitals Act. Whereas it is determined that hospital boards are the "governing body or authority of the hospital," it undermines the board's responsibility in making decisions with respect to the hospital's administration and management. Further, we suggest it may well determine which services our hospital may be able to provide to our community. We suggest that our boards, composed of representatives from the community, signing an agreement that has not been negotiated or agreed to would effectively silence the voice of the community in making fundamental decisions about the hospital services in their community. We suggest that the minister and bureaucrats could unilaterally direct changes to health care services in our community that are not acceptable. We strongly suggest that accountability agreements must be negotiated.

All should be dealt with between the Ministry of Health and the board of governors, not the Ministry of Health and the CEO directly. The CEO is our only employee and definitely should be accountable to the board of governors. If Bill 8 is about accountability, the government has not tabled an agenda or rationale for the bill. Without such an agenda, we cannot hold the government accountable for their role in Bill 8 or for further upcoming amendments. We suggest that it would be difficult for a board of governors to have a commitment

to health care and a commitment to the government if both are not the same.

I might add that the hospital has an auxiliary that has 190 registered volunteer members. The auxiliary represents all service areas of our hospital and, in the last two years, provided almost 25,000 volunteer hours both in fundraising and serving our patients' needs. As indicated earlier, the hospital has been in existence since 1964, and to date the auxiliary has provided to the hospital a total of \$862,617.39. We strongly suggest that without having community representation, this will compromise the hours spent and the monies raised for our community hospital, and the future of the hospital will be seriously compromised. West Haldimand General Hospital also has an organized foundation that has donated more than \$1.2 million in new equipment and renovations over the past five years. These funds are donated locally by the community.

With respect to sections 26 and 27, providing the minister with the power to make orders affecting the employee of the hospital strips the board of its power under the Public Hospitals Act to determine the terms of employment of the senior executive members of the hospitals. If critical decisions with respect to the management of the hospital are made by the minister and the bureaucrats, and not by the local communities, this will erode public confidence in their local community hospital and again affect other volunteers throughout the community.

By putting in place mechanisms to have the CEO report to both the minister and the board and by granting the minister the right to unilaterally alter the CEO's agreement, the minister is interfering with a fundamental principle of corporate governance. The implication of this decision will seriously prejudice the board's ability to represent the interests of the community and to conduct themselves in their role on the board in a businesslike manner.

As suggested by one of our board members at our last meeting, it sets the hospital board of governors as puppets and would destroy the credibility of the board of governors in the community and hence compromise the ability of boards to find dedicated volunteers in the future.

We strongly suggest that the provision of Bill 8 that grants the minister the right to (a) require hospitals and hospital executives to enter into accountability agreements, (b) issue compliance directives to hospitals and hospital executives, and (c) unilaterally alter hospital executives' terms of employment all be deleted from Bill 8. Otherwise, Bill 8 will effectively convert public hospital corporations into government agencies.

We further suggest that the penalty provisions of the bill are inconsistent with the principles of volunteer board governance. Members should not be held liable or be subject to actions when they are acting in good faith on behalf of their community.

The ordering change of employment sections, 26 and 27, have been rejected by the British Columbia provincial

auditor in his review of BC performance agreements as both detrimental to the governance of the organization and ineffective in improving performance.

With the regard to part IV, the Health Insurance Act amendments, subsection 40(3) of the bill would add provisions to the Health Insurance Act allowing the minister, upon the advice of the general manager and where the minister considers it in the public interest, to amend the OMA schedule of fees in any manner the minister considers appropriate. Currently, the Health Insurance Act provides that revisions to the schedule must be proposed by the OMA, not the minister. Such orders by the minister could result in unfavourable financial consequences to hospitals should the minister significantly lower the amount payable for certain insured services. We do not believe that the power to propose changes to the schedule of fees should be left to the OMA or to the minister without consulting interested parties. We also suggest that among the stakeholders, hospitals should participate and be consulted with respect to the schedule of fees that may affect them.

Our conclusions: We suggest that accountability agreements must be negotiated and that the independent nature of the relationship between the health care providers and the government be characterized by trust, mutual respect and collaboration, and that there is a requirement to respect community input through the role of the local voluntary governance of public hospitals. Also, we suggest that there must be due process for circumstances where an agreement cannot be negotiated or where there are disputes or misunderstandings. Where the agreements have been complied with, the bill should provide for government accountability.

It would appear that the accountability in Bill 8 is currently one-sided and is inconsistent with the government's commitment to a shared approach of accountability. Bill 8 fundamentally undermines the government's accountability to medicare, and the minister is no longer required to act in the public interest as defined in the Public Hospitals Act. We also suggest that Bill 8 excludes any legislative requirements to fund the system adequately, as set out in the accessibility provisions of clause 12(d) of the Canada Health Act, which, in the case of hospitals, stipulates that "The health insurance plan of the province must provide for the payments of amounts to hospitals with respect to the cost of insured services." We suggest that Bill 8 should define the key principles of the Canada Health Act and provide definitions for "accessibility," "universality," "medically necessary," "comprehensiveness" and "quality."

Finally, we suggest that Bill 8 must be amended to ensure that communities have a say in the services they provide and how the local hospital boards are managed; to ensure that both providers and the government are held accountable by Ontarians for health care they receive; and to ensure that Ontarians have access to the health care services they need, where they need them and in a timely fashion.

Lastly, from a very personal perspective, many hospitals have for many years had the benefit of very

stable boards, consisting of experienced and knowledgeable trustees. These people simply have a very committed interest to pure health care in their community as it affects the bigger picture. I am afraid if Bill 8 comes to fruition in its proposed form, many of these trustees will find themselves rendered useless in their roles and will likely cease to continue in their various positions on hospital boards.

The loss of this valuable asset to the hospitals, to the community and to the Ministry of Health will be devastating to local health care everywhere, especially to small urban hospitals in Ontario.

I'd like to thank you for allowing me the opportunity to present this.

The Chair: Thank you, Mr Barnhart. You've left us with about a minute and a half each for questions, starting with Mr Kormos.

Mr Kormos: You've talked about accountability, and I couldn't agree with you more. I was so heartened when the Ontario Health Coalition in Toronto the other day proposed direct election of hospital boards from the community the hospital serves, something I've believed in and advocated for a long time. What's wrong with that proposition, if anything?

Mr Barnhart: From a personal perspective, it doesn't bother me. Direct election of hospital board representatives would be fine. As to how the other board members would think about it, I don't know.

Mr Kormos: It would be the same way we elect city councillors or MPPs or trustees on boards of education. That, to me, is accountability.

Mr Barnhart: Except it goes back to a problem we've discussed on our board for many years, and that's payment. If a person is elected, they probably expect to be paid. We don't get paid, and we don't expect to be paid. It takes our accountability to a little different level. We're there because we really want to be there. We're not there for a particular amount of money.

Mr Kormos: You want to be there.

Mr Barnhart: That's right. We want to be there, but we don't want to be there for payment. That's what has always—anyone who is elected to any office is normally paid something. That's the only issue I have with it.

Mr Kormos: OK. Thank you.

The Chair: Ms Smith.

Ms Monique Smith (Nipissing): Thank you, Mr Barnhart. We appreciate your presentation today. Are you aware that the minister presented to this committee last week a framework for the amendments that are going to be brought forward with respect to this legislation?

Mr Barnhart: I've read a few of those amendments, yes.

Ms Smith: I'll make sure you have a copy. I'd just note that many of the concerns you've raised today are addressed in the framework for amendments, including a definition of senior staff with respect to the Ontario health council, a definition of a health system organization. Basically, we're looking at stakeholder groups, not boards of hospitals, so board members would be

entitled to sit on the council. Payments to hospitalists—you were concerned about that—will be addressed in the amendments. Greater whistle-blowing protection with respect to queue-jumping will also be addressed. The fact that the accountability agreements will be between the board and the ministry, not the CEO and the ministry, will be addressed. The fact that the accountability agreements will be between the board and the ministry, not the CEO and the ministry, will be addressed. I think that will go some way to quelling your concerns about interference with governance. Some of your other concerns are also addressed. I'll make sure that you have a copy of this.

I just had one last question. Would you be in favour of negotiated accountability agreements between the ministry and hospitals?

1040

Mr Barnhart: Yes. Can I make a comment about your remarks? We had drafted this speech and rewritten it a few times. I realize, from reading the amendments on the weekend, that some of those things were addressed. However, those are only proposed amendments, and this was actually a written presentation. Because they are only proposed amendments, we wanted to make sure we got our point across.

Ms Smith: I appreciate that input. Thank you.

The Chair: Mr Hudak.

Mr Hudak: Thank you very much, Perry, for the presentation. The Chair and committee members may know that Perry served as a board member at the Haldimand War Memorial Hospital in my riding, in Dunnville, recently recognized as one of the top hospitals in Ontario.

I'm glad you're here. I think you made an outstanding presentation. Despite my colleague the parliamentary assistant's discussion on what is actually an outline of amendments, not actual amendments, I think what we're worried about on the opposition side is that it's written in the same disappearing ink their campaign platform was written in. I think it's important to keep pressing these issues. They could have come in at any time during these hearings and actually put amendments on the table. We could have altered the bill as we went along to assuage some of the concerns that small hospitals have.

I think you make an outstanding point, well put, that this bill, if passed, would make local volunteer boards of governors mere puppets to the Ministry of Health. I think that was well put by one of your board members in the presentation. I'd like you to reinforce a bit another concern you brought up that I think is important: small-town hospitals are having a great deal of difficulty recruiting doctors. Sometimes they have to make alternate funding arrangements to recruit doctors, particularly for emergency and on-call services. Can you discuss again the importance of that for communities, like in Haldimand county, and how this bill would interfere with them?

Mr Barnhart: In our community hospital in Hagersville, we only have really five or six doctors who provide

services in the hospital. Because of the lack of family physicians, well over half of our emergency visits are people who don't have GPs, so they come to the hospital and have to be served by our doctors. There has to be some kind of incentive available to do that. We have over 18,500 emergency room visits, and without enough GPs it's almost impossible to deal with that number of people.

The Chair: Thank you for coming today. It was appreciated.

CANADIAN UNION
OF PUBLIC EMPLOYEES,
LOCAL 7100

The Chair: Our next delegation this morning is from the Canadian Union of Public Employees, local 7100, Hotel Dieu hospital. Stephen Palmer, the president, is with us this morning—and somebody else, obviously. If you would, introduce yourselves for Hansard when you do begin. You've got 20 minutes. You can use that any way you like. At the end of your presentation we'll split the time amongst the three parties that are represented here, starting this time with the Liberals. I've got 10:45 and you've got 20 minutes.

Mr Stephen Palmer: Good morning. My name is Stephen Palmer and I'm making this presentation on behalf of the members of CUPE Local 7100, of which I am the president.

CUPE Local 7100 represents 530 service and clerical employees at the Hotel Dieu Health Sciences Hospital in St Catharines. The jobs we perform include paramedical services for the Niagara region, diabetic services for Niagara, addiction intervention, both male and female, regional dialysis services and a multitude of services provided by a full-service general hospital.

We bring to this committee the experience of front-line hospital workers, I myself being one for the past 33 years. Many of our members have served Ontario hospitals for decades. Although we receive little of the glory, our work is vital for the functioning of Ontario hospitals. Our members provide the core of Ontario hospital services even in the face of such diseases as SARS, West Nile and a multitude of other such illnesses. We are the backbone of hospital infection control. We have faced hospital-based infections. We have campaigned for public health care. We have fought privatization, still are going through hospital restructuring, and we are constantly called upon to defend the rights and dignity of hospital workers.

We have, over the past eight years, had to constantly live with the threat of hospital closures and job loss. We have dealt with stress day after day while always putting our patients and co-workers first, because the staff of Ontario hospitals are there out of a duty of commitment and loyalty to the people they serve.

The Ontario Liberal government introduced Bill 8 with great fanfare on November 27, 2003, less than two months after being elected. The members of local 7100 agree that Bill 8 holds some worthwhile goals, most of

which are already set out in existing legislation. But the bill also creates some serious concerns for the health care industry. Bill 8's preamble is filled with noble sentiments. There is little that is new, however, and little that is not already present in Bill 8's predecessor, the Health Care Accessibility Act.

Minister Smitherman touted a promise made on P3 hospitals, which has already been broken, when he introduced Bill 8. While the Liberals campaigned against public-private partnership hospitals during the election, they are now implementing a similar model of P3 hospital in Brampton and Ottawa. Hundreds of jobs will be privatized, and well over a billion provincial health care dollars will be turned over to giant for-profit trans-national corporations. We find it hard to see how Bill 8 puts an end to creeping privatization, particularly as we have learned that this government has allowed six other hospitals to investigate redevelopment using public-private partnerships.

This raises questions from our membership about how seriously we should take the government's stated purpose concerning Bill 8. Is there another agenda? A better start for Bill 8 would have been for the government to shut down the for-profit clinics and make P3 hospitals public facilities.

The part of Bill 8 that is of greatest concern to our members relates to part III, sections 19 to 32. Specifically, we are concerned about the broad powers of the Minister of Health to require accountability agreements or to issue compliance directives. While the government has made much of the accountability set out in the act, one must note that the accountability in this part of the act is accountability of health care providers to the government and not accountability of the government to the public it was elected to serve.

These provisions have been drafted in extremely broad and general terms. They grant the ministry virtually unprecedented power to require individuals and organizations to comply with the health care initiatives. Potentially these steps could override collective agreements or other negotiated agreements.

Under the provisions, the ministry can direct any health resource provider or any other person, agency or entity that is prescribed by regulation to enter into accountability agreements with the ministry. The term "health resource provider" is broadly defined. A trade union, for example, might well qualify under the broad definition of "health resource provider."

The ministry is also empowered, in section 22, to "issue a directive compelling a health resource provider or any other ... person, agency or entity to take ... any action that is specified in the directive or to comply with ... prescribed compliance measures." There is little limitation on the scope of such directives.

The ministry's discretion is as wide as the government determines it should be. These powers could be used for health care reorganization, hospital restructuring, privatization or other initiatives.

Section 27 of the bill even provides that where an order makes significant changes in a person's terms of

employment, including a reduction in compensation, these changes shall be deemed to have been mutually agreed upon between the person and his or her employer. Under the bill, a health care union and an employer could be ordered to address certain issues through collective bargaining and, in the event they fail to do so, could be ordered to reduce wages or benefits or eliminate no-contracting-out or successor rights language contained in our collective agreements. Just as bad, the minister could simply issue a compliance directive requiring the collective agreement protections to be modified or overridden entirely.

1050

Under part III of the act, hospitals could be ordered to consolidate services such as housekeeping, laundry or food services, and require collective agreements to be altered to facilitate these changes. Regardless of any restructuring, the minister could simply order a reduction in wages and benefits for our members. In a free and democratic society, we should not have to resort to counter-arguments to address such a potential threat to collective bargaining.

Taken together, all of part III could be viewed as an attempt to bestow upon the minister and the government virtually unlimited authority to order and direct fundamental changes to the health care system and to do so in a top-down dictatorial manner, without any traditional procedural safeguards or limitations.

The bill seeks to insulate the crown and the minister from any legal liability resulting from any actions taken in connection with accountability agreements or compliance directives. On the other hand, anyone who fails to comply with an order by the ministry relating to accountability agreements or compliance directives is subject to prosecution and if found guilty may be subject to a fine of up to \$100,000.

Service and office employees are some of the lowest-paid employees working in the hospital system, and yet we are presently the main target of hospital privatization and restructuring. The privatization of hospital services in British Columbia has meant mass layoffs and a radical reduction in workers' compensation. Our livelihoods, our homes and our future retirement are on the line. We take any threat to our collective agreements very seriously. We hope this committee will too.

We have endured massive hospital restructuring under the previous Conservative government, and in our view it did little or nothing to improve the hospital system. It did, however, disrupt the lives of tens of thousands of hospital workers and their families.

We work in the dirtiest environment one can be subjected to, and we are under constant threat of any number of communicable diseases, some life-threatening. Still, we persevere. Constant changes and restructuring only add to the tremendous stress we find ourselves working under on a daily basis, stress that at times is passed on to the people we serve.

While the last round of hospital restructuring did little to improve the previous government's popularity, at least

there was a process in place for some consultation with the community through the Health Services Restructuring Commission. Bill 8 raises the possibility of restructuring through ministerial directives, a much worse possibility. We cannot understand why the Liberal government would choose to proceed in such a high-handed and brinkman-like manner. It raises great danger for a health care system that has already been under great stress for a number of years. We had hoped the new government understand this.

We support many of the principles of Bill 8. Universal medicare is Canada's most cherished social program. It helps define us as Canadians. We are not sure why the government chose to introduce Bill 8, which gives such sweeping powers to the Minister of Health and Long-Term Care. However, legislation does not turn on the intent of the legislators; its power arises from the meaning of its words.

We would like to pass on to you in written form key changes required to deal with our concerns about part III of Bill 8: First, no trade union shall be required to enter into an accountability agreement or be subject to a directive; second, no collective agreement shall be the subject of an accountability agreement or directive; third, no accountability agreement or directive shall directly or indirectly affect the continued operation and enforceability of a collective agreement or amend its terms; fourth, no employer shall be ordered to enter into an accountability agreement which directly or indirectly interferes with the provisions of a collective agreement; and fifth, notwithstanding sections 21, 22, 26, 27 and 28, no accountability agreement entered into under section 21, compliance directive entered into under section 22 or order made under section 26 shall (1) directly or indirectly affect the continued operation and enforcement of a collective agreement, (2) try to amend, vary or discontinue the terms of a collective agreement, (3) require the parties to a collective agreement to amend, vary or discontinue the terms of a collective agreement and (4) directly or indirectly interfere with the ability of the parties to a collective agreement to comply with the terms and conditions of such an agreement.

CUPE and other health care unions have been told by the Minister of Health and the government not to fear Bill 8, and that its intent is not to override or interfere with collective agreements, as was the case with Bill 29 in British Columbia. We say, make the changes we seek and put trust back into government.

We also believe the government should reconsider the powers the bill may give to the Minister of Health to reorganize and restructure health care. The hospital system has already undergone extensive reorganization over the past eight years. Allowing the minister to unilaterally impose more is a recipe for strife and chaos that may well push hospital employees to the brink.

Canada is one of the most desirable places on earth to live, and our health care and the dedicated staff supporting it are one of the main reasons Canada stands out above most other countries. Slowly but surely our health

care system is being eroded. A once-envied health care system is now one falling into disarray from constant government interference and mismanagement.

On behalf of the 530 members of local 7100 that I have the privilege to serve, I would like thank you for your time and interest.

The Chair: Thank you, sir. You've left us with about six minutes. We're going to start with the government.

Ms Smith: I think she has—

The Chair: Oh, I'm sorry.

Mr Palmer: There's a continuance, Chair.

The Chair: OK, then you have six minutes left.

Ms Lydia Mazzuto: Greetings to the members of the committee and opposition members and members of the public who have come today. I sit here today as a member of CUPE 7100. I am a former executive member of the Ontario Health Coalition and a co-chair of the Niagara Health Coalition. There is an attachment that has been added.

The Chair: Could we have your name as well?

Ms Mazzuto: Lydia Mazzuto.

The attachment that has come with the CUPE 7100 presentation that Steve gave is entitled Bill 8: A Closer Look. This is a presentation component that we are doing to highlight some of the issues that we feel are very important and that the bill needs to address a little more closely. Those three key areas are: privatization; the importance of support staff workers in the health care and hospital sector; and the very important aspect of the uniqueness of individual communities, particularly the Niagara region.

Bill 8 is a proposed piece of legislation based on the provincial Liberals' election platform. Its primary goal was to enhance the Canadian health care act. While the legislation purports to defend the principles of the Canada Health Act, Bill 8 does nothing to defend or truly address comprehensiveness, accessibility, universality and the single-payer system.

Part I of the bill provides for the establishment of the Ontario Health Quality Council, consisting of nine to 12 appointed members reporting to the Minister of Health and Long-Term Care. This is an appointed council, not representative of a democratic council accountable to the public. There are no restrictions on appointing members who have a financial interest in for-profit health corporations to sit on council. Its purpose is not to provide accountability and monitor the prohibition of a two-tiered health system.

Interestingly, it would report and monitor, but not provide recommendations on, areas the bill's preamble defines as a primary focus of the bill: promotion and protection of the Canada Health Act. Restrictions on recommendations are only on future areas of reporting, not ones already approved by the minister. The minister need only table a "report" that presumably has to do with the council's own annual report within 30 days of receiving it. The public, again, is not privy to the council's submitted report, only the minister's response to it.

Contrary to putting an end to privatization, this bill invites it, reminiscent of hospital services privatization in British Columbia. Unionized workers there were laid off en masse after similar legislation was passed in 2002 that saw drastic reduction in salaries and, for many, the elimination of hard-won benefits. Hospitals already account for a decreasing share of health expenditures, in terms of expenditures per capita and overall share of costs.

We would caution the continuous move toward the privatization of hospital services by looking at and applying a private sector management approach in order to deal with reduced budgets. Private sector management approaches that mimic commercial management approaches, like total quality management, have already been seen in the hospital sector. With an emphasis on cost effectiveness and value-added business philosophies more suited to the hotel and tourism industry, hospitals and health care programs will suffer. In recent years, hospitals have implemented this odd approach to health delivery—again, an approach more suited to hotels than hospitals.

Instead of reducing services, some hospitals are already contracting out services to private, for-profit companies. A large number of hospitals purchase their laundry, cleaning, environmental and dietary services from commercial companies. Commercial competition has its drawbacks, especially when we can track the move of hospitals to reduce their own services until they are just a skeleton. This creates a long-term, even permanent, dependency on private companies who see profit value, not public value, as their bottom line.

1100

Interestingly, the motivations of profit-seeking corporations are in direct conflict with the principles of comprehensiveness, accessibility, universality and the single-payer system. Fluctuating administration fees alone are taking a toll on hospital budgets. Hospitals are already finding out that while services may seem cheaper at the onset when contracted out to companies with non-union employees, quality and consistency have already had their effect on patients.

Undoubtedly, front-line and support staff are a large part of hospital budgets, but equally so, the same people are cost-effective in themselves. Purposes varied, it is the establishment and consistency of qualified health care and support workers that help keep extra costs away:

—Cutting staff in order to close beds and discharge patients earlier, or not admit them at all, has often led to higher rates of readmission and significant declines in a patient's physical and emotional health.

—Qualified registered nursing assistants provide front-line care. RPNs have already been downloaded more responsibilities that were once only provided by registered nurses.

—Qualified unit aides support all aspects of care.

—Full complements of dietary staff help keep patients safe; for example, diabetic or pre-diagnostic patients from being served unsafe or improper food, which can cause harm and extended hospital lengths of stay.

—Cleaning and maintenance staff reduce rates of hospital-based infections. In the wake of international public health threats like SARS, it's very crucial to recognize this.

I'm going to just skip through a little bit.

The importance of the unique community needs of the Niagara region: Unique community needs are not addressed through this bill or its proposed unrepresentative council. Niagara region, like all communities in Ontario, is unique in its own identity. Our region is both rural and urban, and has industrial and commercial pockets, while still trying to maintain our prime agricultural, natural and protected lands, parks and conservation areas. Niagara has the second-largest senior population in Canada, and its current estimate of 17% is expected to increase significantly over the next several years. As our senior resident population grows, so will our health care needs.

According to 2004 demographics, Niagara's residents have a higher individual cost of health and personal care expenditures than many communities in Ontario. Much credible research like that of the World Health Organization supports the theory that income and poverty levels have direct impacts on an individual and their family's health. While some of our communities face an unprecedented decline in their income levels, effects on health care are at greater risk of declining too. Niagara has lost thousands of jobs and is currently facing thousands more lost jobs and declines in real income. This is a serious threat to the health of our citizens.

Niagara's unique geography embraces an international boundary with the United States. At one time, special needs as a tourism centre were the most recognized factors in specialized demands for our health care system. In recent times, both disaster preparedness and local and international public health challenges add to our discussion. In 2003, Niagara's chief coroner stated that disaster preparation should not be reduced to concerns of terrorism. Niagara's busy industrial sector and its proximity to the border and energy generation facilities mean the region needs to be ready for more common disasters such as chemical spills.

Niagara's hospital and its staff need to be ready and able for these very real concerns. We implore you to take our concerns seriously and make real and effective changes to Bill 8, changes that would truly support the goals of a strong public health care system.

The Chair: Thank you, Ms Mazzuto. That was about as close to 20 minutes as you could get. We appreciate that. If I hadn't interfered, you guys would have had it perfect. Unfortunately, there is no time for questions, but we do appreciate you coming today.

PROVINCIAL COUNCIL OF WOMEN OF ONTARIO

The Acting Chair (Mr Kim Craitor): Hi, Kim. I like that name. You're here on behalf of the Provincial Council of Women of Ontario. The rules are pretty

straightforward. You have 20 minutes. If you don't use up all your time, there will be time permitted for each of the three parties to ask you questions. Go right ahead.

Ms Kim Stasiak: It's a pleasure to be here today. Good morning to the members of the standing committee on justice and social policy, and thank you for this opportunity to come and to speak to you. I'm presenting on behalf of the Provincial Council of Women of Ontario. It was established in 1923, and I want you to know I am not one of its original members. I am presenting on behalf of our provincial president, Jacqueline Truax, who lives in Etobicoke.

The Provincial Council of Women of Ontario represents many thousands of citizens within this province whose aim is the betterment of conditions pertaining to family, community and society. Each year, Provincial Council of Women of Ontario affiliates research and develop policies in areas of concern, such as health, safety, education, the environment, land use, justice and senior issues, which are presented in our annual brief to the government at Queen's Park. The Provincial Council of Women of Ontario is composed of six local councils in London, St Catharines, Windsor, Hamilton, Toronto and Ottawa, and 13 very diverse province-wide organizations, such as the Elementary Teachers' Federation of Ontario and the Older Women's Network.

Provincial Council of Women of Ontario is also an affiliate of the National Council of Women of Canada, which was established in 1893 and has developed strong policies on health care. Provincial Council of Women of Ontario is committed to the principles of the Canada Health Act, believing that quality health care is for all Canadians and should remain universal, portable, comprehensive, accessible and publicly administered. Therefore, we are pleased to have this opportunity to present our views regarding Bill 8, and help realize what its title claims: a commitment to the future of medicare.

We actually want to ask you some questions about the bill. In order for Bill 8 to be fully supportive of the future of medicare and the principles of the Canada Health Act, as well as responsive to the health needs of Ontario citizens, it needs to clearly set out how it will enhance all the above-stated principles. A bill for the people should be well understood by the people it is to protect. With this in mind, we ask the following questions.

(1) What is in the bill to ensure public delivery of health services rather than public-private partnerships?

The discussion of more P3 hospitals, further private clinics and private CT and MRI services has not gone away under the newly elected provincial Liberal government. In fact, they are back on the burner again and making headlines. The Council of Women is concerned that public money may be used to pay rent or, as the revised government contracts state, mortgage payments to the private sector in these private-public health care ventures.

For hospitals, the risk lies in a reduction of hospital beds justified in the name of efficiency, reduction of staff in the name of cost savings, and decreased levels of

service for high interest and profit returns. This is 15% to 25% for private profits or 15 to 25 cents out of every health care tax dollar. If it goes for private partner salaries and stockholders' returns on investments, it is not going toward health care. How is this more affordable? How is this protecting accessibility and decreasing waiting lists that were prioritized under Bill 8?

1110

If Bill 8 is going to stop two-tier health care and add provincial protections for the Canada Health Act, it should include prevention of further private partnerships in this public domain. This has not been made clear or well defined in Bill 8. We support publicly funded and operated hospitals as a better investment for better care, for healthier communities and for a shared public well-being.

To back our view, we note the evidence from Great Britain, which showed that private-public partnerships led to actual staff reductions, fewer hospital beds, and decreased levels of service in the name of cost savings in the health sector. In fact, a 30% reduction of staff occurred and 26% of the beds were closed.

Also, our American neighbour has pursued health care in the private sector and actually reversed the shared public-private provision that we now have in Canada. In Canada we presently have an average 70-30 split of public to private sector, while the US has developed into a 30-70 combination of public to private. This was a relatively fast change of provision in the US in less than 10 years and people were left out, and they continue to be left out. Over 43 million Americans have no coverage, and over 100 million have inadequate health care coverage. It costs twice as much per American citizen to provide this private sector care. One of the richest and most powerful countries in the world rates higher than Canada in infant mortality rates, and while Canada ranks second in the world for life expectancy, the US rates 25th. This is not an indicator for such change here.

A significant risk factor for the private sector is the higher cost of borrowing. This, and the necessity to make a profit for investors, leads them to charge more on public mortgages or rents, take control of non-medical services such as housekeeping, kitchen, maintenance and laundry, and cut corners in actual service delivery.

Further risks of these private-public ventures are that it may well reduce public donations to hospitals as well as community contributions, that collective and individual money gifts to these facilities could be affected, and that it could discourage volunteer hours. Even corporate donations from local industries or business may disappear. When a private partner is taking profit out of the services, many will not add to this possible profit-taking. This could very well happen, and it may already have negatively affected TVOntario. In that case, rumours of privatization make the public nervous about donating until its future as a public broadcasting station is assured.

The accountability you want enshrined in this bill can only come with public ownership. Do not fall victim to the recent claims that ownership does not matter as long

as we are still publicly administering the health care service or paying with our OHIP card. The private control over mortgage and non-medical support services will cost more and the public will reap the losses in health care.

Most important for the Provincial Council of Women of Ontario, these private-public partnerships could be the thin edge of the wedge for the actual dismantling of the Canada Health Act. With this concern are the world trade agreements and that the profits made in such hospitals can then be demanded by foreign investors. Our public and national control could be lost even further.

(2) What services is the government intending to preserve, and is cost control the only motive in Bill 8?

We have seen what has happened in our home care services when funding is the only consideration or motivation. The private sector appeared to offer a better deal and underbid the non-profit provider. This was an effect of frozen funding to community care access centres, who were forced to hire the cheapest service providers through the bidding process. This was compounded not only by the funding limitations but the increasing caseload as patients were discharged from hospital quicker and sicker. Hospital staff can testify that many of these patients came back into the hospital with problems of pain control, infections, or inability to cope without assistance in their everyday needs and living. This is well known. As well, longer waiting lists occurred, fewer patients qualified or were even allowed such covered service, many went without, and a higher, more complicated level of comprehensive care was needed in the community.

Cheaper was rarely better. The historically reliable VON and Red Cross often lost contracts because they could not pay health professionals or well-trained staff their deserved wages and ensure appropriate staff levels in order to underbid the many private, sometimes American, and often unknown agencies. Many nurses who remained were given unreasonable workloads and time restraints to do their treatments and care. This created stress, frustration and burnout. The cheaper agency used less-qualified staff. This added to patient dissatisfaction and distrust. Certainly this is a concern Bill 8 needs to address.

In Bill 8, discussion of funding appears mostly in the form of meeting government requirements, with actual penalties for CEOs and their administrations if budgets aren't therein adhered to. Hospitals can even lose their funding for such failures. This is cost control, but it's not accountability. Adequate budgets must be mutually decided, and the Ontario Health Council should have input.

However, local needs do vary, and even provincial requirements can change in the course of a year. SARS and what happened in the spring of 2003 is our best example and is certainly not a lesson we can take lightly. It cost lives of patients and professionals. Our hospitals were running on bare-bones funding that not only caused failure to maintain infrastructure; proper isolation rooms and units were also limited or non-existent because of bed and ward closures. We can barely meet the everyday

demands in our hospitals now, but when such an outbreak occurs we are unable to meet safe standards of care. Demands and control of budgets are not solutions unto themselves. We must assess and determine the needs on an ongoing basis. If the government desires spending accountability in our health care services, it must make sure the necessary dollars are there to provide the service, or nothing is accomplished in this bill.

Regulation of costs can be achieved by ensuring proper staffing levels for patient care. This prevents added costs we now pay for overtime hours worked, costs of recruitment measures as discouraged staff leave, or compensation costs for overworked and injured health care workers.

Another solution, and to support the publicly administered system we want for health care under the Canada Health Act, is to change appointments of boards of directors for hospital and other health care organizations to elected members. This is also true democracy within the system. Appointed boards of directors may be sincere individuals, concerned for the community's well-being, but rarely have prior knowledge of day-to-day operating and patient care issues. Elections would be more likely to look into the qualifications of a candidate for this position.

The other concern is that—and this is off the record—the CEOs have had choice in who was appointed on their boards. I know that the gentleman from West Haldimand General Hospital spoke to the fact that it was a volunteer position, and it is an important job. It was also very prestigious; it was an honour to be there. Sometimes the CEO recommended you. Well, if the same CEO who recommended you comes back and says, "I think I need a raise, Joe. I work very hard. You're going to do that for me, right?" it puts that member in an awkward position. Actually, it puts them in a position of conflict. So that is why I would like to see elections. We do want more democracy and transparency.

1120

The Acting Chair: You have a minute left, Kim.

Ms Stasiak: OK. How did that go so fast?

(3) How does Bill 8 ensure proper levels of care and coverage, and include meeting staffing requirements?

Bill 8 talks about regulations by the health minister in consultation with and provided by the new Ontario Health Quality Council. We're happy to see this and do believe the health council can begin a public process for further improvements and suggestions to help our cost savings, develop best practices, provide better assessment of patient outcomes and care, and also assist in continued quality health care for an ever-evolving system. These are more of the mandates that these councils need to have. It would also be good to look at electing these officials and making sure they have proper qualifications for the job.

Our system has been stagnant for years, with claims that exorbitant costs and limited funding are the reasons we couldn't keep up or improve. This is a myth. It costs more not to provide adequate funding. Late or delayed care or insufficient care in our hospitals, nursing homes

and communities costs the government more. Lack of staff and services has done this over the years. Emergency rooms have become catch-bins to downed community service and non-urgent care due to lack of family physicians in the community. This is too expensive for routine problems. Primary care reforms must be brought in.

Neglect of untreated high blood pressure can lead to strokes and disabilities. Shortness of breath could just be a minor chest cold or it could be pneumonia or serious congestive heart failure. Instead of a simple water-reducing pill or antibiotic, it ends up that the patient comes into emergency in the middle of the night and is in ICU for a few days but his doctor's appointment isn't for a week. Long waits for knee or hip replacements due to arthritis mean longer recoveries and less independence. Diabetics can end up on dialysis if they're not monitored properly. Cardiac patients who have to wait for angiograms and angioplasties may have another coronary or heart damage. Cancer patients run the risk of advances in their disease. These complications cost and they're due to delayed care. Staffing and the availability of health professionals has become the issue.

Hiring full-time now will solve 50% of the nursing shortage. Providing improved work environments for nurses and doctors will retain and attract more. Hiring graduate nurses full-time from this year's nursing programs will immediately help your shortage concerns. This is not evident in Bill 8, but it is necessary.

Conclusion, finally: The Provincial Council of Women of Ontario look forward to the government's response to our many concerns with Bill 8. As the bill goes forward to its final reading, we trust that you will make the necessary changes to more clearly prevent further privatization of services, preserve key services that will save money in the long run and ensure good patient outcomes and provision of care. More important, we trust the final legislation will truly be a commitment to the future of medicare.

The Acting Chair: Thank you very much. Unfortunately, we don't have any time for questions. I'm glad you were able to get your closing comments in, in the last minute. Again, thank you very much for taking the time.

Mr Kormos: Chair, I know you know and Mr Hudak knows and I know, but the rest of the committee doesn't know that Ms Stasiak has been a driving force behind the survival of public health care here in Niagara region, and the folks down here are very grateful to her.

The Acting Chair: Well said, Peter.

Ms Stasiak: Thank you, and I trust you will be too.

ST CATHARINES AND DISTRICT LABOUR COUNCIL

The Acting Chair: Our next presenter is the St Catharines and District Labour Council, Sue Hotte, who is the president, and Malcolm Allan.

Mr Kormos: Sister Hotte and Brother Allan.

The Acting Chair: Let me finish. Thank you, brothers and sisters, for coming. You have 20 minutes and, time permitting, we'll have questions from each of the three parties. I'll let you start off, Sue.

Ms Sue Hotte: Thank you for the opportunity to present.

The St Catharines and District Labour Council represents 36 union locals and 15,000 unionized workers in the area north of the Niagara Escarpment stretching from Niagara-on-the-Lake to Grimsby. We have long been involved in many economic and social issues in our communities, such as health care, and we welcome this opportunity to speak to you today.

We are all very concerned about the state of our health care system, a system struggling with huge financial shortfalls and shortages in medical professionals. The previous government's policies have resulted in the virtual elimination of organizations such as the VON, the proliferation of user fees and the establishment of private MRI and CT clinics and P3s.

The newly elected Ontario Liberals ran on a platform of change. They promised to invest in health care, education and other essential social services, to eliminate public-private partnerships, P3s, and for-profit MRIs, CT and CAT scans. They have followed through on their promise to reform the health care system with the introduction of Bill 8, the Commitment to the Future of Medicare Act, to replace the existing Health Care Accessibility Act.

Unfortunately, we have serious concerns with the present draft of Bill 8. We would like at this time to draw your attention to some of its major weaknesses and to offer our views on how some sections could be changed.

If we look at the preamble of the bill, it supports the principles of a publicly funded and administered health care system as currently found in the Canada Health Act. Unfortunately, it does not further the implementation of these principles. It leaves the door open for a two-tier system, extra-billing and user fees. There is also nothing in the draft legislation which addresses the concerns with pharmacare and primary health care.

Mr Malcolm Allan: Ontario Health Quality Council: The Ontario Health Quality Council, as outlined in part I, sections 1 through 6, is only to monitor and report to the public on the following: access to publicly funded health care services, health human resources in publicly funded health services, consumer and health status, health system outcomes, and continuous quality improvement. They do not have to monitor and report on whether or not they conform with the principles outlined in the preamble of the bill. These are (a) the principles of public administration, comprehensiveness, universality and portability as enshrined in the Canada Health Act, and (b) two-tiered medicine, user fees and extra-billing.

Our second concern regards the selection of the members for each council. There is no accountability to the public since the public will not elect the members. The process is neither open nor transparent. Decisions are made behind closed doors. Will the council be inclusive

and have members from diverse groups such as patients, health care workers, patient advocates and others? Will one or more members be from the public or from the for-profit sector? Will all who have a conflict of interest with the principles of the Canada Health Act be excluded from the council? The Ontario health council should be democratically selected, and all decision-making should be open and transparent.

A third concern we have is that the Ontario health council cannot make recommendations as to how the health care system could be improved upon and how it is conforming with the principles stated in the preamble. This begs the question, why set it up, a powerless body? Is it only to placate those advocating for accountability and transparency? The Ontario health council must be empowered to make recommendations for future actions and directions which have a positive impact on our medicare system.

Opting out and extra-billing: We support and applaud subsection 9(2), which eliminates the right of a physician or designated practitioner to receive direct payment from patients for insured services up to the OHIP maximum. Unfortunately, subsection 9(4) gives the government the right to reverse Bill 8's regulations, thus opening the door to extra-billing and opting out. We support the ban on extra-billing and opting out.

1130

Ms Hotte: Looking at queue-jumping and P3s, we're very pleased with the part of section 15 which prevents queue-jumping. In other words, a person cannot pay for a certain test or procedure, for insured services, in advance of another person. Unfortunately, since the list of medically listed services is restricted, people who select those services are not protected from queue-jumping. For example, private MRI clinics are allowed to provide scans to those who wish to have one. These people are able to jump the queue and get one before someone who really needs it.

Looking at P3s, the newly elected government campaigned against the privatization of health care, and they should follow through on their promises. Public-private partnerships, or P3s, and the delisting of services should be stopped immediately. The decision of keeping the ownership of the Royal Ottawa and William Osler hospitals public through a mortgage does not change the private, for-profit character of a P3 organization. Experience in Great Britain and Australia of P3 hospitals has shown that the costs will be at least 10% higher. We are very concerned about the announcement that the West Lincoln hospital may be applying for a P3.

Private health care costs more than public health care. In order to attract investors and satisfy their shareholders, private corporations must make a profit and be competitive, at the expense of the patients. For example, the statement of ethics of Anagram ResCare Premier, an American for-profit health care provider for brain-injured patients in six locations in Niagara-on-the-Lake and St Catharines, informs us that it is "dedicated to assisting persons with acquired brain injury to reach their

potential. We do this by providing the highest-quality and most cost-effective community-based rehabilitation and residential services.... We are committed to creating a rewarding and challenging environment for employees and a reasonable return for stockholders."

Until recently, the 44 clients or patients in the six locations were served by one registered nurse, and this was only on the day shift. There are still no registered nurses on the evening and night shifts. This is certainly cost-effective and impacts the bottom line of this corporation. It raises many questions as to the quality of care these patients, or clients as they are called by Anagram, receive. Who gives out the medication? Are the patients over-medicated at night? It certainly is a challenging environment for the employees, as they must do the best they can with the training they received from ResCare Premier. I would like to add, if they don't do what they are told by their administrators and managers, they are at risk of losing their jobs, and they don't want to do something they're not trained for.

How accountable are for-profit companies? One only has to look at the fiasco of Royal Crest, a service provider of 17 long-term-care and retirement homes serving 2,400 seniors in Hamilton, Burlington and Oakville. In the past 10 years, this corporation received over half a billion dollars from the Ministry of Health. The owners made over \$6 million, and now they're declaring bankruptcy. This would never happen if these facilities were publicly owned and administered. Furthermore, the government would have had at the very minimum an additional \$6 million to spend on health care.

Private stand-alone MRI clinics are not publicly owned and operated. They drain money from the public health care system through third party billing. They deprive the hospitals of an important income source. They aggravate the severe shortage of skilled medical professionals as they are able to lure staff from the hospitals with promises of better salaries and working conditions. They also promote queue-jumping, as people will pay for medically unnecessary services.

Home care also shows us the negative impacts of privatization. Precious health care dollars are being spent on expenses surrounding tendering requests for proposals, preparing bids, evaluating proposals, monitoring, and of course profit-taking. The VON is still operating in the Niagara region, in part because of financial support from such groups as the local United Ways.

Mr Allan: Accountability agreements and compliance directives: We are extremely concerned with sections 19 through 32 of Bill 8. They cover the powers of the Minister of Health to compel persons to enter into accountability agreements or compliance directives. The present wording would allow the minister, if he or she wishes, to override legal collective agreements and other negotiated agreements. This goes against the democratic principles of our society and what the trade union movement stands for, more specifically, not only the labour movement within each individual local but under the umbrella of this particular labour council.

The powers granted to the minister are too broad, open-ended and unclear. For example, according to the provisions, the minister could direct any health care provider, other agency or person to enter into an accountability agreement. We would like to see provisions in Bill 8 which clearly explain what accountability would consist of. All Ontarians support a high-quality, fiscally responsible health care system, but it must be a publicly funded, publicly administered health care system. As representatives of the St Catharines and District Labour Council, we are committed to public medicare and oppose any language that supports a privatization agenda.

Sections 26, 27 and 28 of the bill are a direct attack on health care workers, who do a fantastic job in a financially starved public health system which is chronically underfunded and understaffed. The minister would have the power to unilaterally change a person's terms of employment. The minister could reduce funding, change funding or discontinue any terms of a contract or agreement of employment. Why would anyone want to choose a career in health care or stay and work under those uncertain circumstances?

Ontario is at risk of losing 6,000 RNs in the year 2004 and up to 23,000 RNs by the year 2006 due to retirement, burnout, finding employment in another profession or in another political jurisdiction. According to the CIHI RNDB 2002 report, Ontario already has the worst RN-to-population ratio in Canada. In 2002, it was 65 per 10,000, compared to 78.6 per 10,000 in the rest of the country. Here in Niagara, the Niagara Health System has been vigorously recruiting family doctors, nurses and other medical professionals in order to address huge labour shortages which impact on a daily basis on the quality of health care that people in Niagara are receiving.

Regarding trade unions' and employers' right to free collective bargaining, in the name of value for money or fiscal responsibility the minister could force them to reduce wages and benefits, or both, repeal their no-contracting-out language or their successor rights clauses. To us this is totally undemocratic and unacceptable.

Why does Bill 8 give the Minister of Health such sweeping powers to unilaterally dictate fundamental changes in the health care system without procedural safeguards, democratic input or transparency? Why does it give the government the power to prosecute anyone who does not comply with the minister's order? Why does this bill not allow people to take legal action against the minister or the crown? Is the answer to all these questions that the newly elected Liberal government wants to privatize as much of the publicly funded and administered health care system as possible? Is it because the Premier and the Minister of Health want to reinvent government and pave the way to the privatization of all public services? Given the powers and penalties in sections 26, 27, 28, 29 and 30, we call for their complete withdrawal.

In conclusion, we were hoping that Bill 8 would explicitly prohibit two-tiering for so-called medically unnecessary procedures, strengthen accessibility and pay

special attention to marginalized, equity-seeking and geographically remote communities. This community certainly isn't geographically remote, but I think the statistics you heard prior to us and the ones we presented to you show that we are in desperate need of servicing and yet, I would suggest, the last time I looked at the map we looked to be at the heart and centre of this province. Heaven knows what it's like to live in northeastern or northwestern Ontario. What kind of service is actually provided up there when you truly are remote?

1140

Recognize that for-profit health care hinders accessibility to health care, and have provisions on pharmacare and home care. We're really waiting to see and hear what this government's response is to those two components of health care. It seems a mute response at best.

There will be a lack of democratic participation and transparency because of the sweeping powers given to the Minister of Health. Ontario does have a debt. We recognize that. We go to the table every week. We understand the needs of employers. We understand their constraints. But our public services, including health care, have deteriorated because of the previous government's policies. Restructuring, efficiencies and the selling of public assets such as the LCBO or TVO are not the solution. The previous government's policies dramatically reduced the revenue available to the government. The solution is to increase the revenue stream and, in so doing, improve upon our medicare system.

Voters in Ontario rejected—and I stress “rejected”—privatization in the form of P3s. The evidence we have from Britain and Australia shows us that public services worsened under those particular aspects.

We urge the government of Ontario, in light of our comments, to reconsider this bill. We thank you for this opportunity.

On an anecdotal note, I'll mention about the British experience with P3s, since I happen to be a very old immigrant from that particular country; I came here as a very young child.

Interjection.

Mr Allan: I'm old enough.

Mr Kormos: He's at least as old as we are.

Mr Allan: That's right, and of course that's not that old.

In any case, the majority of my family still happens to live in Scotland. The last time I was there, five years ago, in the Strathclyde region outside of Glasgow, which encompasses the entire city of Glasgow, the human outcry against another P3 hospital was deafening. Not only my family but their friends were saying, “This has cost us not only time in waiting longer for the National Health Service to take care of us, but it has cost us more money. We are now paying greater taxes to pay for a so-called private-public partnership than we did when we built the old Glasgow General Hospital,” which of course was a shambles by that time. What they got was this lovely thing up on the hill that looked beautiful, but it cost them a fortune to build, administer and run.

If you publicly fund a private institution that doesn't take any risks, has no competition—I'd go into business myself if that was the case, and I've never owned a business in my life. But if someone was going to give me a guaranteed revenue stream, ask me to take no risks and simply say to me, “You don't have to worry about collecting the debt. We'll send you the cheque every month. Don't worry about it. You pick the services that you like and you can farm out the others to the public sector because those are the tougher ones to do,” why wouldn't I be lined up in a queue saying, “Pick me, pick me, pick me”? That's why they're lined up at this border, quite frankly, looking to say, “Pick me, pick me, pick me.”

It's not British entrepreneurs that invested in and started P3s in the UK, it's American insurance companies. They are the masters at it. We have seen that they pay a higher per capita of GDP than any nation in the world. Are they healthier? If you look at the WHO reports about health worldwide, Americans aren't at the top of the list, and yet they spend the greatest amount of money.

Our assertion to you is that to follow the model of a P3 hospital and P3 partnerships in a publicly funded health care system will ultimately cost us money. “Us” is the taxpayer. We give you our taxes, and we ask you to administer them. We also have the right, as your electors, to give you direction. I believe that's what we're saying to you. I believe that's what you've heard this morning. I believe that's what has been said in this province for the past 15 years. It's incumbent upon you, I believe, as an elector, as part of this democracy—I'm also the holder of an elected office; I understand those types of pressures that come upon you. But at the end of the day it is we, the payers of this system and the electors and the people of the province of Ontario, who have an absolute right in this society to give you direction, and it's incumbent upon you to take it. From that point of view, you need to hear what we're saying around P3s, and that is no: no to the two that were proposed under the previous government; no, we don't want them; and yes, we want them repealed. We don't want any others, especially the one up in West Lincoln. You folks have said that's where we might see one. Guess what? If that's the case, you'll probably see a lot of others.

The Acting Chair: Thank you, Malcolm. You have conveniently used all of your 20 minutes. I was hoping we'd have some opportunity for some questions. I appreciate your comments. I thank you and Sue and the St Catharines and District Labour Council for participating. Certainly your comments will be looked at by this committee.

Mr Kormos: How many workers do you represent?

Mr Allan: We represent 15,000.

WEST LINCOLN MEMORIAL HOSPITAL

The Acting Chair: The next presenter we have is from the West Lincoln Memorial Hospital. Welcome, Kathryn Curran, chair of the board, and David Bird, the

executive director. The format is 20 minutes. Time permitting, we'll be allowing for questions afterwards. Whenever you're ready, just go ahead and start.

Ms Kathryn Curran: Good morning, ladies and gentlemen. My name is Kathryn Curran, and I am the chair of the board of directors of the West Lincoln Memorial Hospital in Grimsby. We are a Niagara community that you would likely see as you pass by on the Queen Elizabeth Way on your way here to Niagara Falls.

West Lincoln Memorial is a 60-bed community hospital. It serves a catchment population of approximately 60,000 people who live in the Lincoln, Grimsby, West Lincoln and Stoney Creek areas. We offer a full range of services at the hospital. We see over 27,000 patients in our ER per year. We perform over 3,500 surgeries annually and deliver close to 500 babies, many delivered by their family physician. In partnership with McMaster University, we are a major training centre for family physicians and other learners.

We have ended our past four fiscal years with a budget surplus, and this year we are projecting a 6% surplus. As we have done in the past four years, we will use part of these funds to expand services and shorten wait-lists for our communities. Part of the surplus will go for capital development, as we are doing all this good work in a 55-year-old building.

With community and contractual partners, we have shared resources, reduced overhead and entered into joint buying agreements. We even make our own electricity and heat through an environmentally conscious, natural-gas-fired cogeneration plant. All of our cost savings through these partnerships have gone back into clinical programs. As an example, we have increased our total surgical volume by over 60% in the last five years.

I am here today representing my board, the hospital and the west Niagara community as a whole. As a board, we have discussed the provisions of the Commitment to the Future of Medicare Act. We had an ADM from the ministry come to our board and give educational sessions regarding accountability agreements. In general, we agree with the key provisions of the bill: establishing the quality health council, embracing the five principles under the Canada Health Act, adding accountability as the sixth principle and entering into accountability agreements.

We understand that the Minister of Health and Long-Term Care, the Honourable George Smitherman, has recently proposed some amendments to this bill, and we agree with the direction of the changes proposed. The problem is, the proposed amendments do not go far enough.

1150

We are deeply concerned regarding certain provisions of this proposed legislation, particularly as they relate to the role of our board, the role of the ministry and the role and accountability of the executive director.

As you have been told in other presentations, boards of hospitals of Ontario are made up of dedicated volunteers, and we are no exception. As a board of directors

with 16 members, we have a community minister, our local Grimsby fire chief, physicians, three municipal town councillors, an auxiliary representative and several other elected and appointed members of our communities. Each director comes to the board as a highly trained professional, with years of experience and skills which each is prepared to bring to the board. In addition, each director is well known and knows well the members of our community.

Sections 21 and 22 of the proposed legislation offend us, as local representatives of our communities. We have a responsibility under the Public Hospitals Act, and we fulfill that responsibility diligently. To require us to sign an accountability agreement that we have no ability to negotiate is a bastardization of the term "negotiation" and destroys faith, not only with us but with our staff and ultimately our community as a whole.

We are very concerned regarding sections 26 and 27 of the legislation—other areas that also have not been substantially changed with the proposed amendments. Either we have accountability for the actions of our executive director or we do not. There should be no direct authority by the minister over our executive director if the minister is not directly accountable for all the actions of the hospital. This hybrid approach is harmful, it will not work, and you know it was harshly criticized in British Columbia when the model was reviewed by the BC Auditor General.

Bill 8 is one of the first major pieces of health legislation brought forward by the new Liberal government. We, the hospitals of Ontario, have been under the gun in the past year, trying to cope with SARS, the flu, West Nile virus, chronic working capital deficits and operating budgets that are finally settled five weeks before the end of the fiscal year. How are we supposed to interpret proposed legislation that appears to be a direct assault on our local decision-making? Does this give a good signal for future working relationships in an area that is priority one for the citizens of the province?

As a board of directors, we urge the government to make a decision: Either maintain and facilitate local governance of hospitals with boards that are responsible and accountable to their communities, or remove the boards and transfer the accountability directly to the minister. Don't dilute the authority and responsibility of present hospital boards. This dual accountability will cause unnecessary confusion and problems for the executive leadership of hospitals across this province.

Finally, accountability is a two-way street. With all due respect, where is the accountability of the Minister of Health and Long-Term Care in this legislation?

We urge you to consider our opinions and to continue working with the Ontario Hospital Association in drafting revisions to this bill. We are committed to accountability, but we also strongly believe in voluntary governance and local control.

Thank you for allowing me to present to you. David Bird, my executive director, and I would be happy to answer any questions you would like to propose.

The Acting Chair: Thank you, Kathryn. We have six minutes left, and we will start the questions with the official opposition.

Mr Hudak: Kathryn and David, thank you very much for the presentation. It was passionate and very well put.

For the benefit of the members of the committee, the West Lincoln Memorial Hospital serves a large catchment area in my riding of Erie-Lincoln. It does an outstanding job and has substantial community support, whether it's through the board of the hospital or through the volunteers who help make that hospital run, which has been manifested in a very successful fundraising campaign for a new hospital. Part of that is the belief in the local volunteer board making the best decisions for quality care, as well as for accountability.

You use very strong terms here, but I think appropriate. I haven't quite figured this out yet. Minister Smitherman is a smart man. I've seen him in operation in the House. I have a lot of respect for him. But you can't judge this bill by its cover. The way it was described in the Legislature is substantially different from what we've learned in these public hearings. In fact, this movement by the Ministry of Health to take over local hospital boards, to subvert the voluntary governance of the board at West Lincoln and get into a direct relationship with the CEO, is rightly rejected quite strongly in your documents.

They have committed to making amendments, after they were caught out on this, and we've been given promises by the Minister of Health that changes will occur, but we've seen promises by the Minister of Health before.

Despite the fact that they've brought forward some suggested changes, you still think they don't go far enough—sections 21, 22, 26 and 27 particularly. Do you have any advice for this committee and for the opposition members on amendments we can bring forward to ensure that the points you bring out about the board, particularly on accountability agreements, will be enshrined in this law?

Mr David Bird: I think it goes to the part of the presentation that says you need to make a decision. If you dilute the autonomy of the board, then there's going to be a big problem. That's not to say that there can't be accountability, and should be accountability. I think it's fair to say that hospitals in Ontario, through the performance reports that are going through the hospital, reported with the OHA, and basically through local governance, needing to report to the community on an annual basis, that needs to continue, but not to have something that appears to be rammed down our throats.

I guess I was a little surprised when we received from the ministry the notice that the recent funding increases—it came a couple of days ago and we thank you very much, because we need the money and we'll put it to very good use, but we're not sure about all the parts to it—are conditional upon making a notation that this funding is only with an accountability agreement, and I haven't seen any changes to it that makes it more palat-

able to us. So what do we do? Do we say to the community, "We're sorry; we're going to give up \$1.5 million of funding that we know can really be used for the citizens of the community because we don't like the idea that the control could be taken away from the community"? We can't do that. So we're caught between a rock and a hard place.

The Acting Chair: Mr Kormos.

Mr Hudak: I'm just on a roll.

Mr Kormos: Thank you very much for coming. I just want to mention the funding, because I was pleased that Mr Craitor was able to announce in the press the funding for the local health system, but concerned that he indicated it would be of value to people in Niagara Falls, Niagara-on-the-Lake and Thorold, excluding folks from Port Colborne, St Catharines—Mr Bradley's riding—and perhaps Welland. It was perhaps a misquote, because from time to time I understand that happens.

Take a look at this bill. Take a look at section 26, the consequences of failure, which says, "in the opinion of the minister ... make an order ... for one or more prescribed measures," in other words, measures determined in the secrecy of the dark backroom, and then section 30, where there is no liability. In other words, a capricious minister could arbitrarily—Mr Christie is free right now. You remember Mr Christie, who was sent in by the last government to take over the Toronto Board of Education? This bill contemplates perhaps new work for Mr Christie to come in and take over the board of any given hospital or health service.

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There's no liability by the minister. There's no judicial review, because it's in the opinion of the minister. There are no safeguards. There are no checks and balances. This stuff is downright Soviet in its machinations. This is scary stuff. I commend you and other boards for standing up and hitting the nail right on the head. It's scary, scary stuff. I thought we had left all that behind when people voted for change, but they end up getting more of the same.

The Acting Chair: Monique.

Ms Smith: I'd like to thank you for coming and making your presentation today. I, unlike my colleague, actually have some questions, as opposed to making a speech, so I will get to them.

I wanted to congratulate you on your surplus budgets, as well as your shared resources and joint buying. I understand you're doing great work. That kind of co-operation between health care providers is essential, I think, to the lasting presence of those services in our communities.

You spoke of the BC auditor's report and the hybrid reporting approach. I wonder if you could elaborate on your views on how this legislation is in any way similar to the BC legislation.

Mr Bird: I believe the report of the BC auditor was critical of a dual accountability for the chief executive officer position and the health authorities. They felt it undermined and caused confusion in terms of who that

person is going to be accountable to and take direction from. It's great to have one boss, it's maybe a little bit greater to have two bosses, but when you have three or four or five, it's very hard to know who is paying the piper. Essentially, as an executive director, I would look to see who is most likely to get me fired. Is that a way to run a hospital?

Ms Smith: But you're clear that in the proposed amendments that have been put forward in the framework, the accountability agreements will be between the ministry and the board, and not the CEO? You're clear on that?

Mr Bird: I'm not sure what's going to be in those accountability agreements about that and what the reporting is going to be between the CEO and the minister.

Ms Smith: But the accountability agreements themselves, you understand, are going to be between the board and the ministry, and then there is also an expectation that there would be performance agreements between the board and its CEO.

Mr Bird: Under the amendments?

Ms Smith: Yes.

Interjection: We haven't seen them.

Mr Bird: Right.

Ms Smith: But you do understand that those are the—

Mr Bird: And those will be negotiated?

Ms Smith: What will be negotiated? The accountability agreements?

Mr Bird: Yes.

Ms Smith: We would assume that the performance agreements would be negotiated between the CEO and board. That's the relationship that's there.

Mr Bird: What if there's something in the accountability agreement that talks about the performance agreement with the CEO and mandates what has to be in there?

Ms Smith: The accountability agreements will be negotiated, so the board will have an opportunity to negotiate those provisions with the ministry.

Mr Bird: That's good to hear, because I think that's something I've been unclear about, that there will be negotiation, and it will be a true negotiation.

Ms Smith: The minister has stated in the numerous speeches he's given on this that they are negotiating accountability agreements.

The Acting Chair: On behalf of the committee, thank you for taking the time in coming out. We appreciate your comments.

NIAGARA HEALTH COALITION

The Acting Chair: The next presenters are from the Niagara Health Coalition.

Mr Kormos: Chair, while these people are seating themselves, I know you and Mr Hudak join me in welcoming our colleagues to Niagara region. I mention that to demonstrate to the audience that there's no ill will between us. We collaborate, indeed.

Ms Smith, the parliamentary assistant, welcome to Niagara. Ms Smith, of course, is the author of the now well-known dress code resolution in the Legislature. She and I have more in common than many would suspect, because recently the Toronto Sun selected us as the worst-dressed female MPP and worst-dressed male MPP, respectively. But I was noted as being rumpled in a sexy sort of way.

The Acting Chair: Order. Thank you, Peter. I want to ensure that the presenters have sufficient time.

We have with us Diane Cormier, co-chair of the Niagara Health Coalition, and Sue Hotte, who is also a co-chair. You have 20 minutes. Time permitting, the remaining time will be divided equally among the three parties for questions. Go ahead whenever you're ready.

Ms Diane Cormier: First of all, I'd like to thank the committee for allowing us to make this presentation.

The Niagara Health Coalition is a member of the Ontario Health Coalition, which is a network of more than 400 organizations representing hundreds of thousands of individuals in all areas of Ontario. Our local members include the Council of Canadians; seniors' groups such as ARM, Retired Teachers of Ontario, CAW retirees; nurses; health care workers; 36 union locals; and concerned citizens in Niagara-on-the-Lake, St Catharines, Thorold, Lincoln and Grimsby. We are a nonpartisan group committed to maintaining and enhancing our publicly funded and publicly administered health care system in Ontario and in Canada. We work to honour and to strengthen the principles of the Canada Health Act.

Bill 8, entitled the Commitment to the Future of Medicare Act, was introduced late last fall as the fulfillment of the present government's promise to enshrine the Canada Health Act in Ontario law. It is to create a health quality council to monitor, to provide accountability and to prohibit two-tier health care.

Upon reviewing Bill 8, we found that not only does it not further the implementation of the principles of the Canada Health Act but it also does not improve democracy, transparency and accountability. We also found that it will not prevent the further erosion of the scope of medicare, privatization and profit-taking, and two-tiering for those services that have been delisted. We are also very concerned because the bill gives the Minister of Health sweeping powers.

Given our concerns, we would like to present the following recommendations which could strengthen the bill by implementing the principles of the Canada Health Act. In so doing, the present Liberal government would be able to fulfill its election promise on health care reform.

Rebuild a commitment to the universality, comprehensiveness and accessibility of medicare.

Ontario's public health system has been seriously eroded by years of cuts and delisting of services. According to the February 2004 report of the Niagara Health System, Niagara is even worse off than the rest of Ontario. The Ontario Medical Association reports that over 900,000 Ontarians have no access to a family

doctor. In 1999, our region had the second-lowest number of physicians per population than the provincial average. The ratio was 60 per 100,000 in Niagara, compared to 85 per 100,000 for Ontario. This means that 5% of our population is without a physician. Although the Niagara Health System has recruited 28 family physicians and 35 specialists since 2001, we are still underserviced by 75 physicians. This has led to a high rate of emergency use and overcrowding.

Between 1996 and 2001, the number of RNs and RPNs decreased 7.5% and 0.6 % respectively, compared to the provincial average of 3.3% and 2%. The effect of this is that in 2002, the ratio of RNs to population was 566 per 100,000, compared to the Ontario average of 695 per 100,000.

Over \$100 million in OHIP services have been delisted over the last decade. This includes audiology testing. It now costs between \$50 and \$75 for each test and hearing aid evaluation. Many medications, such as Effexor, an anti-depressant, have been delisted. This impacts those who are on disability. Surgery for sexual reassignment was also delisted. We used to be able to have a yearly eye exam; now it is once every two years. Many people, especially seniors with failing eyesight, need to have an examination at least once a year.

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Funding cuts are responsible for the loss of 11 full-time positions for addiction treatment in Niagara in the past two years. Due to funding cuts, the Niagara Health System cannot deliver certain mental health services because it had to reduce its mental health staffing levels by 19. It is only receiving \$13.29 per capita, compared to the provincial average of \$51.76, to fund mental health services. Niagara, according to the Ministry of Health and Long-Term Care benchmarks, should have 736 mental health beds. We only have 188.

I'm going to ad lib here just for a second, if you will bear with me. The previous government eliminated the 2.25 nursing care hours per day a resident receives in a nursing home as a minimum care standard. Non-profit and municipally run nursing homes and homes for the aged might still maintain this minimum standard of care. Personally, I work in a privately owned nursing home. With the standard for minimum hours of care removed, that allows them to channel more of the money into their profits.

I work a night shift. My hours are from midnight to 7:30 am. Between the hours of 6 am and 7:30, I am responsible for attending to seven residents. In that hour and a half I've got to wake them, wash them, dress them, get them up, and there is always some other unexpected event that might occur which will take up that time.

Basically, for privately run facilities whose big concern is profit, it creates a heavy workload, and residents—how can I put this? We do our best to provide the care they deserve. I never leave at 7:30. I'm always there until at least maybe 7:45 or 7:50. But that's my personal choice, because I think these residents deserve as much time as I can give them. Sometimes I feel like I'm on an

assembly line. I shouldn't feel that way, and these residents deserve better.

Carrying on, I'll skip to page 3.

The principles of the Canada Health Act are incorporated in the preamble of Bill 8. Unfortunately, the bill does not provide concrete initiatives to ensure access to the services which have been cut and to implement the sentiments outlined in the Canada Health Act. As noted in the preamble to the bill, home care and pharmacare are key components of rebuilding an accessible, comprehensive, universal public health system. Homemaking and support services, access to primary care, access to drugs and assistive devices, and a comprehensive OHIP list covering the people are also very important. We need real, concrete steps to ensure that all Canadians have access to a comprehensive range of medically necessary health services.

Prohibit two-tier medicine and extra-billing.

Fundamental to the universality of the public health system is the prohibition of two-tier medicine and extra-billing. The threat of two-tier health care has grown significantly with the privatization of the health system. User fees, service charges and two-tier access generate great revenue for the private health care providers. Furthermore, the delisting of services and procedures has allowed the growth of two-tier access for uninsured services. Some examples are as follows: Private laboratories can now charge for pickup and delivery. This affects long-term-care facilities and home care patients. Private MRI/CT clinics can provide medically unnecessary scans to those who pay out of pocket. Therefore, those with the least medical need can jump the queue. Inadequate home care budgets have led to massive cuts to home nursing, homemaking and personal support services. Those who are unable to pay for the services are more susceptible to ending up with preventable injuries and illnesses.

Bill 8 must be changed in order to, first of all, protect against two-tiering all the services which have been delisted, and secondly, stop the two-tiering for so-called medically unnecessary scans that are allowed in the private MRI/CT clinics. The present government campaigned against P3 hospitals and private clinics. It should fulfill its campaign promises to stop and reverse these privatizations.

We support and applaud the prohibition against physicians and other practitioners opting out of OHIP. However, we are concerned that the wording of the bill allows this protection to be reversed in the regulations, therefore providing less protection than we already have in Ontario law. Government should not allow physicians to extra-bill by regulation.

We are totally against block fees. We believe that Bill 8 should simply ban the practice. It violates the principles of the Canada Health Act, as it creates a barrier to accessibility. It is unnecessary, as physicians can charge on an item-by-item basis.

The threat to the future sustainability of medicare posed by private, for-profit corporations is critical. P3 hospitals put billions of dollars of public funds into the

hands of profit-seeking corporations. The veil of commercial secrecy makes it difficult for the public to scrutinize profit-taking and misuse of public funds.

The imposition of two separate sets of management under the same roof, one with a goal of providing a public service and the other with a goal of maximizing profit and growth, is fraught with problems. The higher borrowing costs, consultant fees, legal fees, high executive salaries and profit-taking drive up health care costs. Seeking to satisfy their shareholders, corporations seek new sources of revenue, imposing fees and service charges wherever they can. Contracting out and the hiring of poorly qualified health care workers may help the bottom line, but it certainly does not enhance the quality of patient care. British and Australian P3 hospitals all share the same characteristics: user fees for patients, fewer beds, lower staffing levels and no public accountability.

We can clearly see the effect of privatization in home care services. Since 1996 the Ontario government has been privatizing home care services. A managed competition model has meant that for-profit home care agencies have replaced non-profit home care providers. There is no public accountability for for-profit home care services. There are no province-wide standards for home care. Competitive bidding has replaced direct public funding. This practice has led to a freeze or a decrease in home care wages. The result is a large turnover in staff rates, as much as 60% per year, because the pay is very low and there are usually no benefits. Meanwhile the corporation or the owners are reaping large profits. One only has to look to Hamilton and the financial fiasco of the Royal Crest chain of long-term-care and retirement homes.

Non-clinical services such as food, laundry, maintenance, record-keeping, lab tests and diagnostics should not be privatized. They are essential to infection control, nutrition, diagnosis and recovery. They should be provided on a non-profit basis.

Similarly, the creation of private, for-profit clinics to deliver hospital services poses serious threats to the sustainability of medicare, because access to diagnostics is limited by the supply of equipment, such as scanners, and trained personnel, such as radiologists and technologists. The private clinics find their staff by poaching them out of public hospitals, leading to staff shortages in public facilities. They are able to access new revenue streams by promoting medically unnecessary scans. In addition, the private clinics take the less risky and less costly scans, leaving the heavier-burden scans to the public system, which has been deprived of personnel. Like ResCare Premier (Anagram) in the Niagara Peninsula, they also take third party billing patients and those on WSIB, depriving hospitals of this revenue. These clinics make profits not only from their clients but also at the expense of the public health system.

One only need look at the incredible increases in the cost of drugs—an area of the health system—to see the high costs and threat to public access posed by privatization. Since 1995-96, Ontario's drug costs have

soared 130%, and the pharmaceutical corporations top the Fortune 500 list.

Fundamentally, the motivations of the profit-seeking corporations fly in the face of the principles of comprehensiveness, accessibility, universality and the single-payer system. The Canada Health Act calls for the public administration of our health system. Private hospital corporations, private long-term-care corporations, private labs and private home care corporations are a serious threat to the future sustainability of Ontario's health system.

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The Liberals' pre-election promise was very clear: They opposed privatization, and they were committed to rebuilding medicare. That being the case, Bill 8 should strongly show their commitment to the future of medicare. It must include concrete initiatives to roll back privatization and to prohibit future for-profit control of our health care institutions. P3 hospitals must be banned. The private diagnostic clinics must be returned to non-profit hospitals. The tide of privatization sweeping across our health system must be stemmed. The future sustainability of medicare and the application of the principles of the Canada Health Act depend on it.

We urge the government of Ontario to reconsider Bill 8 and, in so doing, to strengthen the legislation and truly support the principles of the Canada Health Act. Thank you for the opportunity to participate in this very important decision.

The Acting Chair: Thank you very much, Diane. We have three minutes left. I will start with Peter. You'll be entitled to one minute to ask your question and get a response, and we'll do that around the table.

Mr Kormos: That's time to inhale. Thank you very much. It's most appropriate that the person immediately following you is going to be addressing the issue of the VON and participation in home care. She's right there, waiting anxiously to get up to the table.

The issues are clear, and they aren't being addressed by Bill 8. I'm not going to ask you a question. Your report is comprehensive; it's complete. Do you know what's fascinating, though? Shelley Martel has been working on this committee and I've just been filling in from time to time. In all the hours I've spent—which hasn't been a whole lot—there hasn't been one single participant in these public hearings who supported the bill.

Mr Frank Klees (Oak Ridges): Not one.

Mr Kormos: Have there been any? I'm sure the Liberals will come up with one or two before it's all said and done.

I would like legislative research to tell us if there has ever been a bill that has required more amendments than this one, in the 15 and a half or 16 years that I've been at Queen's Park.

The Acting Chair: Thank you, Peter. I appreciate your comments.

Mr Kormos: Thank you kindly, Chair. I'm sure you do.

The Acting Chair: I always do. You're a wealth of knowledge. Ms Smith.

Ms Smith: Thank you for your presentation. We really appreciate it. As you know, we came out to the public for input on this bill after first reading and we are looking for this kind of input, so we appreciate your being here.

Mr Hudak: It wasn't voluntary, exactly.

Ms Smith: Of course it was voluntary. It was always the intention to bring this after first reading.

I won't let him eat into my one minute. I did want to ask a question, as opposed to giving a speech, like my colleagues again.

With respect to block fees, you said you oppose block fees. I just wonder, are there any circumstances in which you would support block fees? I think of a situation where there's a family that has a number of unlisted or not covered expenses and where the block fee structure would be well set out for them: "These are the fees, these are the options. You can pay for them individually or there is this block fee option. There are no strings attached. It won't mean that you can't have this doctor." All those kinds of protections would be in place. Would that be the kind of scenario where you could see it happening, or do you just not want to see block fees at all?

Ms Sue Hotte: No block fees. If they have to pay for services that have been delisted, my suggestion to the government is to make sure they get listed again. If they're in a situation where they need a great deal of health care—

Mr Kormos: Applause.

Ms Hotte: Applause.

The Acting Chair: Thank you very much. Tim, I'm going to let you have an opportunity to say a few words.

Mr Hudak: Other members were there in the assembly, but I'm sure that when Minister Smitherman introduced this bill, it was all motherhood issues about getting rid of privatization and two tiers. I don't remember him saying, "Do you know what? This bill is really screwed up, and there are going to be all kinds of amendments." Am I right?

Mr Klees: That's right. He did say it at committee.

Mr Hudak: He did say that at committee. OK.

Mr Klees: He was embarrassed.

Interjection.

The Acting Chair: Let's have some order. Thank you for your question.

Mr Hudak: Hold on a second; that wasn't close to a minute.

The Acting Chair: That's the minute. You took up your minute.

Mr Hudak: No, it wasn't even close.

The Acting Chair: Thank you very much for coming out. I appreciate it.

Mr Klees: You got shortchanged.

Chair, while the next presenters are coming forward, if I could, this is really for your benefit as well as the rest of the committee. I want to make it very clear for the record that the previous government put forward five bills to

public hearings after first reading. I know statements have been made that somehow this government is treading on new territory, new ground. The fact is that it was the previous government that introduced the concept of putting a bill out after first reading. However, there was never a bill that was in such terrible condition as this one after first reading, ever.

The Acting Chair: Thank you, Mr Klees.

Mr Klees: Thank you for that opportunity.

The Acting Chair: You've very welcome.

Interjections.

The Acting Chair: Order. Let's show some respect for the deputants.

Ms Kathleen O. Wynne (Don Valley West): Sorry.

Mr Kormos: I want the record to show that chaos erupted—

Mr Hudak: From the Liberal benches.

The Acting Chair: Not from the Chair, though.

ONTARIO PUBLIC SERVICE
EMPLOYEES UNION, LOCAL 269,
HAMILTON VICTORIAN
ORDER OF NURSES

The Acting Chair: We'll start out by welcoming you. Thank you very much for participating. Sorry we're running a little bit behind. Lois Boggs, the president of the Ontario Public Service Employees Union, local 269, and the Hamilton Victorian Order of Nurses—you have 20 minutes and, time permitting, we'll then allow questions by the three parties. Go ahead whenever you're ready.

Ms Lois Boggs: My presentation is very short, and don't feel you need to spend the whole 20 minutes asking me questions when I'm done.

I'd like to start by thanking you for this opportunity to speak to you about Bill 8 and this government's decision to gather public opinion before passing a bill that is so important to us all.

I am a client service representative at the Victorian Order of Nurses, Hamilton branch, where I have worked for the last 18 years. I'm also the president of OPSEU, local 269, which represents all nursing and clerical employees in this branch.

I'm not here to speak to you about the whole bill. I don't pretend to know all about it. I do want to focus on the health quality council and community health care.

I want to talk to you today about the changes that have taken place in community care these last eight years and the devastation to our home care system. This is my story about the cost of privatization in community care.

Eight years ago the Victorian Order of Nurses administered the home care program. The visiting nursing visits in our region were contracted to two not-for-profit agencies: the Victorian Order of Nurses and St Elizabeth nursing. Home support was contracted by the Visiting Homemakers Association, which was another not-for-profit agency. The rate the government paid each agency

was negotiated provincially, and the three agencies worked well in collaboration with the home care program and delivered quality care to people in their homes as needed.

Then came the community care access centres, managed competition and divestment of direct staff. The Conservative government told us that community care would be better managed, more accessible and more cost-effective. We know now that nothing could have been further from the truth.

Agencies were forced to compete with each other for service delivery contracts, and new companies, many of them from the United States, went into a bidding war. Wages and working conditions of the front-line workers spiralled downward as not-for-profit agencies like mine struggled to survive. When the CCAC boards continued to run deficits and complained that this was not a more cost-effective system, they were quickly fired and replaced by new boards that were hand-picked by the Conservative government. Since that time, we have witnessed a dramatic reduction in service in every area of home care in this province.

Over 100,000 people are no longer receiving care in their homes. In-home nursing has been cut by 50% and home support by 60%. In the year 2000, my local had 220 members, and it saddens me today to say we have about 130 members left. My agency has lost 90 workers, most of whom were highly skilled community nurses. The Visiting Homemakers Association was forced to go out of business, and 500 personal support workers and homemakers lost their jobs.

The VHA, when it was in trouble, asked the CCAC to increase the visit rate and the CCAC refused. Instead, the CCAC allowed the Visiting Homemakers Association to close their doors after 75 years of service in our community and then contracted other agencies, most of them for-profit agencies, at a higher rate. Just last week the CCAC awarded the new contract for home support in our region. Comcare was not successful and has just had to lay off over 300 workers, and some of those workers were former employees of the Visiting Homemakers Association. When their company went under, they went to Comcare, and now Comcare has gone under.

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The Victorian Order of Nurses and St Elizabeth nursing still provide 85% of all visiting nursing visits, but both agencies have lost many workers and continue to pay low wages due to the competitive process. During the last RFP, the CCAC advised the nursing agencies that if they increased the rate for visits, there would be an identical reduction in the number of visits; for example, if the agency increased the rate for visits by 10%, the CCAC would reduce nursing visits by 10%. In other words, 10% of people requiring nursing care would not be eligible. The visits would disappear.

The Hamilton CCAC has a budget of nearly \$50 million. I had the opportunity last week to visit the CCAC office and I got to observe first-hand their new office renovations. By the way, this is the third time the

CCAC in Hamilton has renovated their office. "Obscene" is the only word that can describe how these health care dollars were spent on their new, state-of-the-art staff lounge or the room they've built that will soon be a fully equipped gym with a shower. I spoke briefly with a case manager and commented how nice the office was. She replied, "I know the office is nice. It's just too bad it cost somebody their once-a-week bath."

In 1997, my counterpart at the CCAC made approximately \$1,000 a year more than I did. Today she earns \$20,000 more a year than I do. And unless something changes for the community agencies—what you need to understand is that the CCACs have just finished negotiating a contract with their employees—by the year 2005, this office support position in the CCAC will earn more per year than a community nurse. This is not acceptable. These are examples of how our community health care dollars are being spent. Something has to change; it's just not right.

The CCACs have a large budget with no accountability to the public, and information is not accessible through the freedom of information act. While I admire your commitment to the future of medicare, I urge you to strengthen the bill and restore public confidence in our health care system. The public should have the right to know how health care dollars are spent, and they shouldn't be spent on a gym for CCAC workers.

I ask that you put in place public control, public governance and democratically elected boards. I ask that you restore full access to home care, including home nursing, homemaking and personal support. I ask that you put a stop to the competitive bidding and reverse the privatization of community care.

In closing, I ask that the health quality council be assembled through an elected process by groups that represent patients, advocates and front-line workers from the health care system. The council should be truly accountable and can make recommendations for change. No person who has a financial interest in for-profit health care should be allowed to sit on the council. In addition, the council should deliver an annual public report on the health care system.

The Acting Chair: Thank you very much. We have six minutes left, so each party will have two minutes to ask questions, starting with Ms Smith.

Ms Smith: I'd really like to thank you for coming to give us this presentation today. It's always helpful to hear from various groups. We haven't heard enough from the home care sector, so we appreciate that.

I wish I had more time, because I have so many things I wanted to say, but the CCACs will be brought into the accountability agreement framework that's outlined in this bill, so there will be more accountability and there will be agreements and there will be public disclosure. We were actually shocked that the information you referred to is not available under the FOI system, and we're certainly going to be looking at that.

I've met with the VON in my riding, and I've heard very similar stories and a similar passion to what you

expressed today, so we're very aware of the concerns that are out there with respect to home care. We had a very graphic presentation in Ottawa, which included props, which Mr Kormos would have greatly enjoyed, that set out all the different silos that had been built from one system, which just seemed crazy to us. So we appreciate that.

I hope you'll take the opportunity to take the previous government to task in their two minutes for some of the things they have done. But I did want to just read to you a portion of a speech that the minister made two days ago at the Economic Club of Toronto, where he outlined our vision for health care:

"Effective home care services are also very much a part of our plan for putting care in the community."

"Romanow calls home care the next essential service, and we agree.

"Nowadays, services that used to only be provided in institutions can be delivered at home. Home care can offer greater dignity and quality of life. Many prefer the independence of receiving care in their home, but too often this is not an option. And we know that home care is often less costly.

"We are too reliant on institutional care. We are going to change that.

"If what I say about investments in the community, in primary care and home care has a familiar ring to it, this should not come as a surprise. It's been spoken of constantly. But we aren't interested in just talking.

"As a first step to put care in the community, we will invest the federal health accord dollars this year in home care services, catastrophic drug coverage and the development of family health teams. This will help us build our capacity to care for people in their communities and integrate community services with institutional care."

So you've got the commitment from the minister, and you'll be seeing action on that shortly.

The Acting Chair: Mr Hudak.

Mr Hudak: It's nice to have the letter and the written commitment by the minister. I recall a commitment by the minister in this government to scrap the P3 hospitals. We've heard from many presenters today that not only have they gone ahead with the P3 hospitals, but they have more planned. There was an honest debate during the campaign. We had one opinion; the NDP had another. The Liberals' position is substantially different now in office than during the campaign. So we will look forward to Mr Smitherman actually putting action behind his words.

We've heard they are going to make substantial amendments to this bill, but we have yet to actually see the amendments. So we've heard a lot of promises but have seen no action and no promises being kept.

A particular concern that you brought up from the CCACs' point of view is the quality health council and making sure there is good and broad representation on that council. One of the issues we've heard too is their lack of consumer representation on that council. Do you have a view in terms of whether there should be guaran-

teed seats on the council for any particular group? I think you had talked about an elected council.

Second, with respect to the council, you talked about public reporting. One view expressed is that it should report directly to the Legislature as opposed to the minister. Do you have any views in terms of what they should be looking at? I think right now they're restricted to whatever the minister asks them to review.

Ms Boggs: I think they need to be looking at private fees, looking into where our health care dollars are spent, all that sort of stuff. I did read the bill. I didn't want to talk about the whole bill; I just wanted to talk about home care today. There are lots of things happening in our health care system that need to be fixed, but the most important thing, and the thing that I hope is important to every person in this room, everybody who has taken the time to come and talk to you, is that the public want to know. We're sick of not knowing where our health care dollars are going. Everybody is running a deficit. We don't know where the money is going. The CCAC is a prime example.

I will talk a little bit about who should be on the council. The original CCAC boards had consumers and different groups on those boards, and when those different groups complained, they were fired. So on this council I want people—not a guaranteed seat, or perhaps I do. Maybe I want somebody from the Ontario Health Coalition to sit there, so I know that what's coming out and what's being reported is the truth. That is what this should all be about, that we know where the dollars are being spent, we get the truth about where they're being spent and they are not being wasted on gyms and staff lounges.

I don't know if I answered your question, but things have gone so bad in the last eight years that they need to be fixed. I appreciate what you said, but they need to be fixed now. If you took all the money that every one of the 43 CCACs spends right now on administering the RFP process, following it, the whole process from beginning to end—I don't know if you'd need more money; just take the money out of the administration and put it right now, today, into the delivery of the service, and health care would increase in this province. It doesn't take a lot of money; it takes redirection of the money. In my opinion, the CCAC is getting quite a bit of money. It's just not going to client care, and that's what's disgusting.

The Acting Chair: Thank you. Wonderful answer.

We should be adjourning, Peter, but I'm going to allow you the two minutes as well.

Mr Kormos: I appreciate it.

Thank you very much, Sister. Look, I can't quarrel with you. The problem is that just as the last government, when CCAC boards displeased them, fired those boards and put in their hand-picked cronies, their hatchet people, their little marionettes, one of the fundamental problems with this bill is that it enables the minister to do the same to hospital boards if the minister "is of the opinion," and the boards, who are the victims—no, the patients, the

public, who are the victims, have no recourse through the courts.

So I suppose, in this debate between people who were in the former government and people who are in the present government, the frightening thing for me is how much these two governments are similar rather than how they are dissimilar. The Liberals have demonstrated an uncanny ability to campaign like New Democrats but govern like Tories. So your message today is well put and appreciated.

What we want is accountability. Maybe publicly elected boards are the way to go. If you believe in democracy, you won't have little appointed boards, you won't have little backroom deals being struck by small, little cliques, be they cliques of members of a hospital or cliques of government backroomers who appoint their political cronies.

The Acting Chair: Thank you for those questions, Peter.

Ms Boggs: Can I just make one more comment?

The Acting Chair: I will allow you to make another comment, and then we will be recessing. Go right ahead.

Ms Boggs: The problem is that the CCAC board members who were hand-picked by the Conservative government are still in place today. There has been no move by your government to change that.

The Acting Chair: I thank you for your sincere, emotional and excellent presentation.

The committee recessed from 1242 to 1350.

ST JOSEPH'S HEALTHCARE HAMILTON HAMILTON HEALTH SCIENCES CORP ST PETER'S HEALTH SYSTEM

The Chair: Ladies and gentlemen, if we could call the committee to order again, I'd like to call St Joseph's Healthcare Hamilton, Hamilton Health Sciences Corp and St Peter's Health System. Make yourselves comfortable. The rules are that you've got 20 minutes. You can use that any way you see fit. If there is any time left over at the end of the presentation, we'll apportion it between the three parties for questions. The floor is yours.

Mr David Borsellino: My name is Dave Borsellino, and I'm the chair of the board of trustees at St Joseph's Healthcare. I'll introduce Bob Jones, from Hamilton Health Sciences Corp, and Urmas Soomet, from St Peter's.

Thank you for the opportunity to be here today and make a few comments. I'd like to kick off with perhaps a few introductory comments, and then I would ask Bob Jones to step in and talk about a few specific issues that we have.

First of all, in terms of who we are—I think there's a handout—it talks a little bit about the total budget, the total number of beds and employees. In the interests of time, I'll leave that to you to look at at your leisure, but it just describes who we are.

I think the more important question is, why are we here today together? The answer to that is, first of all,

that we are aligned in supporting the philosophy of Bill 8, particularly with respect to the issues of transparency and accountability. I think, though, as we go forward and look at the importance of leveraging the value of the health care dollar, the other thing we're aligned on is that we believe collaboration is an essential part of going forward. We've taken some steps toward that in the Hamilton community among our hospitals.

As we've started down that road, there are some things we have seen. We've seen that the restructuring commission work that was done some years ago has left us a little bit of a by-product: an every-man-for-himself type of approach. I think if you come through a process that from an institutional point of view is survival-based, you tend to hunker down and look within your own organization. As we try to move into collaboration, there are a lot of issues around trust and working together that take some time to implement. So we're in the process of attempting to do that, brick by brick. One of the things we feel is important as we go through that process is that part of it is having a shared vision, a shared set of goals and objectives that you're trying to achieve, and in the final analysis, it's really measured in terms of outcomes.

We're also aligned in terms of coming here today and feeling that this collaboration effort also has to exist between the hospitals and the ministry. As we go forward, we are going to have this issue of shared goals and vision, and when it comes to the issue of accountability, there has to be mutual accountability. This is something we have to come together, and it's going to be one of the keys in terms of going forward. So we do have some concerns about that.

I'd like to turn it over to Bob Jones for some of our further comments.

Mr Robert Jones: Thanks, Dave. The handout, I think, has been provided. I'd just say that in preparation for today's meeting with you, we've gone through various iterations of this presentation and have distilled this down to what we believe are the really key components. We know you've heard from many other organizations like the OHA, of which we are members, and the Ontario Council of Teaching Hospitals—two of us at least are members there. We didn't want to reiterate a lot of that; we just want to focus on the themes we've provided for you here today.

First of all, picking up on Dave's introductory comments, the accountability agreements in our view have to be negotiated and have to reflect that interdependent nature of the relationship of trust, mutual respect and collaboration between the health care providers and government and, furthermore, respect the community input through the role of local, voluntary governance of public hospitals. Those are two fundamentals that we feel very strongly about.

In terms of due process, the handout we provided says, "Bill 8: No dispute resolution mechanism," and that's "a must between partners." Perhaps rather than refer to it simply as a dispute resolution mechanism, what we're saying is that if this is going to work effectively in terms

of providing better governance, better accountability and ultimately better patient care, there may not be a dispute but a circumstance can arise during the course of an agreement where underlying assumptions can change, significant anomalies or events can occur, either provincially or locally or even within an institution. That may be to the benefit or the detriment of either party, but in any event, when those things change, there needs to be an articulated means by which the parties can communicate, review and if necessary revise those agreements based on those anomalies.

In addition, we say in our next slide that we think the amendments should include a guarantee of governmental action in the public interest. We think that caveat is extremely important. It exists elsewhere in legislation in terms of the ministerial authority that the Minister of Health has, and we think it's an important concept that should be replicated in Bill 8.

Recognition of board responsibility and authority: Again, it goes without saying that we believe strongly in local governance and local board responsibility in that regard. As an adjunct to that, it's very important that there be clear roles and responsibilities for both the hospitals and the ministry. We understand that an opportunity for misunderstanding exists in the complex system of hospitals and health care that we have, even with the best intentions of the parties. To the extent that we want to avoid that and effect positive outcomes, these roles and responsibilities need to be absolutely clear.

The next point is the assurance that the minister will receive necessary support from other branches of government in order to deliver on his or her commitments to the hospitals. What we're really driving at there is that we see this as more of a continuum of accountability, that in fact this deal might be through the Ministry of Health but really it is with the Ontario government. In order for the parties to act responsibly, meet the needs of the system and deliver on the accountability agreement, there has to be sufficient funding and there have to be the proper assurances, therefore, that that will not be an issue that interferes with the fruition of those agreements.

Finally, in terms of the materials we've provided, we say that the amendments should include that providers and government are held accountable to Ontarians for quality health care. We certainly believe in that. We're supportive of that. We agree as well that Ontarians have timely access to the health care services they need. We endorse the efforts to ensure accessibility and enhance accountability, but we cannot support the bill without the revisions we've talked about.

We believe that an amended Bill 8 must strengthen Ontario's proud history of community governance—the right for communities to govern their health care facilities—and to protect medicare and its principles.

We believe that communities want to partner with government to deliver better health care but not be unilaterally directed by Queen's Park to act without sufficient community input.

That's the essence of the principles and the ideas we have to provide to you today, based on our experience

and our belief in terms of where we might go in the future.

The Chair: Thank you very much. I appreciate the summary and the brevity of the paperwork.

Mr Jones: I thought you might.

The Chair: If they gave out funding based on giving good summaries, you guys would be winners.

Mr Jones: We gladly accept the award.

The Chair: You've got about three minutes from each party for questions, so we'll start with Mr Hudak. You weren't really here for the presentation but you could probably catch up with it real quick. Do you want me to go to Ms Martel first?

Mr Hudak: Do you know what, Chair? I appreciate the issues the gentlemen brought forward. Having had the chance to sit on this committee and review the bill, I understand the concerns that hospital boards have brought forward on Bill 8.

There's an expression that you can't judge a book by its cover. Well, we certainly can't judge this bill by its cover and what are described as a lot of motherhood issues. Actually, when you look at the details, it's substantially different from the description the minister brought forward upon first reading.

Hospitals from across the province have come forward with very serious concerns about the imposition of the power of the Minister of Health upon hospital boards. In fact, the West Haldimand General Hospital described it as making board members puppets.

The West Lincoln Memorial Hospital described that there is still a great deal of concern about exactly what these accountability agreements are going to entail and if they are in fact creating a hybrid model where the CEO is going to have to respond both to the board and the Ministry of Health. In fact, they asked the government to make a decision: either maintain our system of local governance and the CEO responds to the board, or the Ministry of Health takes over the boards altogether, if that is the true intention of this government. Make one decision one way or the other instead of creating a hybrid model.

Perhaps you gentlemen could describe a bit more the concern with respect to accountability agreements, how they affect day-to-day operations, and the position they will put the CEO or other administrators in if they do have to follow some sort of hybrid model and answer to two masters.

1400

Mr Borsellino: Just maybe a couple of comments on that. I stand back from this a little bit further and look at this issue of mutual accountability. Ultimately, it still has to be measured by outcomes. In a lot of situations where we're trying to address a particular problem, the first thing that people rush to is structure. In my view, based on my past years in a business environment, structure comes last. You have to have some shared idea of where you're trying to go and how you're trying to get there.

We welcome the concept of accountability, but accountability is always a two-sided situation. So in terms of the role of the board going down the road, I

think that's still left to be sorted out. When you look at things, for example, like trying to move from what we have to a whole new environment with respect to the effectiveness of health care, it's going to be a journey. It's not going to happen overnight. We need to be able to plan; we need to be able to execute over a period of time.

When we deal with situations like multi-year funding and being able to put together a set of goals and objectives over a period of time that are not going to change every time we turn around or get into a situation where you're halfway through the year before you even know what your funding is, those types of situations will not result in this being successful in terms of outcomes. So it's really around how we get an agreement on both sides in terms of the direction that we're heading and the tactics we're going to use.

The Chair: Ms Martel.

Ms Shelley Martel (Nickel Belt): Thank you for being here today. You said in your presentation that you want the government to provide for due process, and you point out the dispute resolution mechanism which is the proposal the OHA has put forward. You will know, of course, that in the draft framework for proposed changes that the minister gave to the committee via the parliamentary assistant last week, there isn't a place for a dispute resolution mechanism.

What remains, even in the proposed document, is that at the end of the day the minister has the unilateral right to issue a compliance directive or an order. How do you feel about that? Clearly you have a proposal. This is not a proposal that the minister was even prepared to entertain as late as last Thursday, despite whatever negotiations have been going on behind the scenes. Where does that leave the three of you as chairs of various boards?

Mr Urmas Soomet: Excuse me, I've lost my voice overnight, but I'll do my best. This is really no different than what we've already got. Hamilton has seen supervision from the Minister of Health. That exists already; that potential exists. So even the minister's changes leave that situation unchanged.

From our perspective, when we talk about accountability agreements, it's probably better to think of them framed as partnership agreements and developing commonly shared ideals of where we want to end up and how we're going to get there, and then use the agreements as a framework to get into that process.

Ms Martel: If that's the case, why would you be supporting the dispute resolution mechanism?

Mr Soomet: We still believe there's a need for some flexibility for dealing with changing circumstances and forcing agreement in some fashion.

Ms Martel: Force versus forcing an agreement; is that what you're saying?

Mr Soomet: We need a situation where we can arrive at agreements that are mutually acceptable. The current situation is not completely satisfactory. It exists today and may exist in the future; who knows?

Mr Jones: If I might add to that as well, perhaps to reiterate, while it's referenced as a dispute resolution

mechanism, and that in part may be the purpose, part of what we're looking for is a recognition, notwithstanding parties of good intention and goodwill coming together and coming up with an agreement that exists over a period of time, that things change. If some of the underlying assumptions on which the agreement has been made change—not for any inappropriate reasons; they simply do—then you need a formula, you need a recognition of the right of either party to come back and revisit the agreement in light of those changes and, if necessary, review and revise. That's really what we're driving at.

Ms Martel: And that doesn't exist at present, not in the current bill and certainly not in the framework that the minister released last week. So if we don't see some changes before March 11, which is the next date that I expect we'll see something from the minister, where will that leave the three of you and your boards?

Mr Jones: Certainly we would look for those changes to be included, if at all possible. We're not here to try to suggest each iteration of this and how many iterations there might be going forward. But ultimately, in whatever form this takes, we would certainly be looking for those types of provisions to exist.

The Chair: Ms Smith.

Ms Smith: Thank you very much for your presentation. Certainly, this being the last of eight days of hearings, brevity is very welcome. We appreciate that. Plus my briefcase is getting way too heavy, so this is very nice.

I wanted to just comment on a couple of your points. You talk about the negotiated accountability agreements. On Tuesday the minister made a speech, as you may be aware, to the Economic Club of Toronto on changing roles in health care and spoke about predictable funding and accountability agreements. You talked about the need for stable funding. Is "predictable funding" a similar term? Is that something you welcome?

Mr Jones: Absolutely.

Ms Smith: In view of the way the minister structured it, in the sense that predictable funding and accountability agreements are kind of going hand in hand, do you see that as a positive step forward in the hospital structure?

Mr Jones: Yes. We're absolutely supportive, as we said at the outset, of the notion of mutual and appropriate accountability. As a concomitant piece to that, the predictability of the funding is absolutely a key piece, because absent that it's very difficult to be held accountable for outcomes when you're not sure of the types of revenue or the amount of revenue you have to work with.

Ms Smith: I was interested in your discussion about dispute resolution. When you enter into an agreement, let's say, between the three of you on some joint project or joint effort in the Hamilton area, would your dispute resolution provisions be included in the agreement itself?

Mr Jones: I understand that we do have some agreements. I am not an expert in that area, but I do believe we have some articulation agreements. Certainly as teaching hospitals we have them with the universities, and in there are provisions that recognize the fact that there may be

circumstances that change during the course of the agreement, whether they be disputes or simply material changes in the underlying assumptions or the criteria or the circumstances under which the agreement was made. My short answer is yes, I believe that exists, and I've certainly seen agreements where that exists. That would be the type of thing we'd be looking for.

Ms Smith: Do you foresee that as being part of an accountability agreement?

Mr Borsellino: I think part of the issue there as well is, if you and I were going to enter into some type of mutual accountability agreement to achieve some goals or objectives that were going to be executed in some kind of environment, we would have some principles and understanding that we set out to accomplish, and we would try to capture that as best we could in words. We could have a situation change external to what we were trying to accomplish. If we have a change in that external environment, this is really to provide an opportunity for us to sit down again and say, "What were we really trying to accomplish? Given this unforeseen circumstance, how do we now execute this in the spirit of the original accountability agreement?" as opposed to just saying, "I've done my part."

Ms Smith: That's great. That's exactly what I was thinking. In the framework for change that we outlined, in section 22 we talk about including "notice and other due process provisions, including time frames for notice, to address development of accountability agreements, issuance of compliance directives and orders," and as an example they list "discussion process, meetings, exchange of documents/information, representations that the minister has to consider before issuing a compliance directive or an order."

Within that kind of framework, if there was a change in circumstance that wasn't allowing you to meet an objective in your accountability agreement, could you not see that you would have an opportunity in this process that's going to be outlined in the amendments to bring it up for discussion, to put it before the minister?

Maybe we're talking about different worries, but what I see as a worry is if you've got an accountability agreement and you've got all your objectives, it's all set out, and then something like SARS hits and you've got to rejig the way you do things in order to address that concern. Do you not think that what is set out in our framework for change for section 22 would allow you to make those representations to the minister in dealing with your accountability agreement?

The Chair: It will have to be a very short answer.

Ms Smith: Sorry, it's a very long question.

Mr Borsellino: I think history will tell. A lot will depend on how the ministry responds to those types of situations. Our concern is that it isn't explicitly outlined. So we're unsure at this point in time. That's why we wanted to voice that opinion.

The Chair: Thank you, gentlemen. We do appreciate your being here today.

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CANADIAN UNION
OF PUBLIC EMPLOYEES,
LOCAL 4800

The Chair: Our next delegation is from the Canadian Union of Public Employees, local 4800, Juanita Maldonado, vice-president of St Elizabeth Nurses. Greetings. Please make yourself comfortable. As with all the groups appearing before us today, you have 20 minutes to make your presentation. You can use that time as you see fit. If there is any time left at the end of the presentation, we'll apportion it among the three parties. The floor is yours.

Ms Juanita Maldonado: Good afternoon. I'm a little nervous, so you'll have to bear with me.

The Chair: These people are pretty friendly. I'm just getting to know them. No one has gotten bit yet, that I've seen, anyway.

Ms Maldonado: I'm very glad to hear that.

My name is Juanita Maldonado. I'm here as a representative of CUPE local 4800. We represent Hamilton Health Sciences. We're also a very diverse bargaining group, because our local encompasses community care as well as the hospital sector. We're one of the largest hospital locals in Ontario. Our service and trades members work at the General, the Henderson and MUMC, and we've recently acquired the cancer centre. I am vice-president for the St Elizabeth Nurses community care organization.

Just to give you an idea of what our members are about, we range from plumbers to electricians to carpenters. I represent a clerical bargaining unit. Hospitals have a professional sector, business clerks, social workers and RPNs.

We bring forward today a message from the local. We are front-line workers, and we wanted to give you an idea, more or less, of how we see this bill affecting what we do every day. I'm hoping that once I tell you a few first-hand experiences, it will give you an idea of why we are concerned.

We have had first-hand experience dealing with hospital infections. We've had an Ebola scare. We've dealt with SARS. We have the MRSA concern in the hospitals. We've had to face the possible closure of the Henderson, which we fought and were successful in keeping. The emergency room at the Henderson is very important, and we were successful in keeping that.

The reason I am here today is because we are concerned about the bill and the fact that it can open up our collective agreements. That's the bottom line. We don't want to risk our wages and losing our benefits. I was grateful today for the amendments and to see that one of the amendments refers to trade unions not being involved in that. I'm sure our lawyers will be looking at that and advising us as to the details.

One of the things that goes hand in hand with what this bill does is that when you start talking about collec-

tive agreements, you also start talking about contracting out and privatization. They are all very closed linked. That is a grave concern when you start talking about the effect that lack of funding in the hospitals has and how that spills over into the community and affects people who do not have the resources to stay at home and have care.

I want to tell you three stories. One is the story of a gentleman in our Hamilton community who became a quadriplegic 20 years ago. This gentleman has been fighting for a service that is essential for him to live his life in a way that you and I would take for granted. Andy has allowed me to tell his story. He has continued to be on the CCAC's cutting list. At a time when perhaps a service may not seem essential because the CCACs are in a position where they have to continue to save money and seek places where they can eliminate services, this gentleman has continued, without dignity, to fight for something as simple as allowing him the service to live in a basic fashion every day. I'm not going to get into the details of it; it's quite humiliating. This is a gentleman who paid taxes his entire life and, due to a terrible, unfortunate accident, is now fighting for nine hours of essential nursing service a week. It's disgusting. I don't think we're doing a very good job of taking care of our own, and I'd like to hear what this committee has to say about that.

St Elizabeth Nurses is a not-for-profit organization. Any of the money the company I work for takes, it puts back into the system. It goes to education, better equipment and maintaining the services we really need as essential in the community, so that people can lead lives that are really effective and independent, and that will cost the province less than if we keep cutting.

I'm asking that we take a serious look at Bill 8 and how it is reinvesting in our health care system. I'd like to know, is it part of the general erosion of what's continued at this time? The nursing shortage in our community is something we have to address. We cannot put dollars into lining the pockets of corporations that are coming into this country to take what is ours. If we don't stop and reinvest it in a publicly funded system—I would be very interested to know how changing the act as it stands right now would do that.

A large portion of what seems to be targeted are service and clerical employees, and I really don't think we're going to save a lot of money if we do that, necessarily. I think it's important for us. CUPE has always been willing to sit at a table and talk about what could be beneficial. We've been vigilant about supporting and being there when there have been cutbacks, even for the people we work for, because we believe—I was so grateful to hear those gentlemen who sat up here before me, because I really felt like I'm not alone, coming from Hamilton. We do want to work together. It is collaborative, there is no question. But we need to be honest about the way we spend our money, and we need to be honest about what this bill is doing. Anything that gives unilateral decision-making ability to one person scares

the heck out of me. I don't understand that, and perhaps somebody can enlighten me that way.

We support many of the principles. Universal public medicare is Canada's most cherished social program. Medicare means we don't have to spend a lot on health care insurance, and if we're not spending it on health care insurance, it means we can spend it in our economy and keep the money here. A healthy economy is what we need. That leaves us all more money to spend on ourselves. Canada's health care system is an economic asset.

Our 3,600 members sent me here today, and this is the message they would like me to convey: Please follow through on the amendments suggested by CUPE. Our collective agreements were negotiated fairly and within a process that no bill should be legally allowed to interfere with. But most importantly, we want this government to work with the health care community. Let's focus our energies together on protecting our most valuable resource. The onus falls on this government to do that.

Just before I conclude, these attached amendments are what our legal buffs are suggesting. I'd like to read them to you: No trade union shall be required to enter into an accountability agreement or be the subject of one; no collective agreement shall be the subject of an accountability agreement or a directive, and neither would it affect the continued operation and enforceability of a collective agreement; and no employer shall be required or authorized to enter into an accountability agreement that directly or indirectly interferes with its ability to comply with the provisions of such agreements.

I really appreciate the fact that you listened to me today. Thank you very much.

The Chair: Thank you, Ms Maldonado, you did wonderfully. You've left each of the parties about three minutes to ask you questions, and we're starting with Ms Martel.

Ms Martel: Thank you very much for coming today. I'll try and deal with three of these points. The minister has said there will be changes that will deal with collective agreements; he hasn't said there will be any changes with respect to compliance directives. I just want to make the distinction, because the minister would still have the power to say to a hospital, "We want you to amalgamate your housekeeping services and your food services, and maybe we'll get you to amalgamate your clerical services while we're at it," which would still result in an impact on health care workers and their jobs in the hospital sector. So while there might not be changes in the front door through the collective agreement, there certainly remains the possibility that your members and others could be affected because of compliance directives. Are you worried that the minister still seems to have unilateral ability to issue directives that could still result in changes, in loss of position, loss of staff, even changes in people's wages if it's contracted out and successor rights don't apply? Are you worried that that provision still remains in the bill?

1420

Ms Maldonado: There's not a lot I'm not worried about when it comes to a lot that comes out of the min-

ister's mouth. I'm concerned, because almost every time anybody has said something, it never comes to fruition. Yes, I'm certainly concerned. There's always been a backdoor. It didn't matter which way we looked at it. We've come to a place now where we can look at the rest of the country and see what has happened and hopefully learn from that, which is why we've been proactive and tried to educate. There are parts of the country where they have had direction from ministers, even though they had made agreements, to go ahead and take away from members, but we were still successful through mobilizing the public. When you speak to the public, they are the ones who will make a difference as to whether things happen. That is what I am counting on. I am hoping that, with things like these forums, they will listen. Not only that, it is the state of our health care system; it's not just what our wages are. That's not the only issue, necessarily. Yes, the compliance directives are a big concern. I haven't had a chance to look at the other amendments, but the fact that you say that's still not addressed is a big concern.

Ms Martel: You said it's changing. How is changing Bill 8 going to stop public money going into private companies that provide health care? The bill's not going to do anything about that. That's the sad part about this bill. It's got a preamble that talks about government support for public health care, but it's the same government that is allowing private hospitals to be built in the province using private financing instead of public money. It's the same government that's allowing the private, for-profit MRI and CAT scan clinics to continue. It's the same government that's allowing competitive bidding in home care to continue so that not-for-profit agencies like St Elizabeth, or VON in my community, lose the contract to a for-profit company and some of the money that should go into patient care goes into their profits instead.

The reality of the bill is that it does absolutely zero, nothing, nada to stop privatization of health care services, and that's the shame of it. The preamble is certainly important, but the rest of the bill does nothing to support the glowing words in the preamble, and that's a shame.

Ms Maldonado: But CUPE will be there to watch that. That's OK.

The Chair: Ms Smith.

Ms Smith: We're certainly delighted to have Ms Martel back this afternoon. We've missed that speech, Shelley.

Ms Martel: You'll hear some more this afternoon.

Ms Smith: I'm sure.

I wanted to really thank you for coming out today. It's great that you were able to come and give us your perspective. Certainly, bringing it down to the actual particulars of a particular client you have is very helpful.

We have had a couple of presentations on the CCACs and the cuts to the CCACs, and we're aware of concerns around those. The act we're presently discussing will impose accountability agreements between the CCACs and the Ministry of Health. I think that will go some way to opening up the process at the CCACs, because those

accountability agreements will be public and will force the CCACs to be accountable for the funding they're receiving. So I'm hoping that will go some way to deal with some of your concerns.

You also talked about the nursing shortage, and I just wanted to highlight for you the fact that the minister made an announcement two days ago about funding for hospitals and tied part of that funding directly to targeting exclusively the creation of full-time nursing positions and improving the health and safety working conditions for nurses. So there is a recognition that we do need to make investments in nursing in the province and we're moving forward with that.

You have talked about the amendment framework, that you were aware of that. There was also a letter that went to Sid Ryan last Monday from the minister, after he made his statement to the committee. Did you see the letter to Sid Ryan of CUPE?

Ms Maldonado: Sid spoke on Tuesday.

Ms Smith: But last Monday the minister wrote to Mr Ryan because of the comments he had made. He was very emphatic that Bill 8 will not allow for opening collective agreements or threaten job security. The intent of Bill 8 is that accountability agreements are established only with boards of directors of publicly funded health care institutions. Bill 8 cannot open collective agreements. He also notes, and I note for you as well, that collective agreements are protected by various pieces of legislation in Ontario, including the Labour Relations Act. So while Ms Martel would raise the fear that directives under this scheme of accountability agreements may allow for changing of collective agreements, of course you know that the Labour Relations Act protects collective agreements from being opened up mid-term.

Ms Maldonado: Why would the minister say, then, that it would only affect current collective agreements? If we were already protected by that, why would he say that? I don't understand.

Ms Smith: Your collective agreement is in place until it's negotiated again, right?

Ms Maldonado: Right.

Ms Smith: So at some point there will be a negotiation, and at that point it's up to the parties to negotiate. He's not going to speak for every collective agreement into the future. I assume that's why he made that statement.

Ms Maldonado: That's what I'm saying: If my collective agreement is already protected by another act, why in the bill would it possibly mention that this bill would not affect current collective agreements?

Interjection.

Ms Smith: Exactly, because Mr Ryan is trying to convince people that this act would in fact allow for the opening of collective agreements.

Ms Maldonado: The initial act does say that. Sid didn't tell me anything initially. So why—

Ms Smith: The bill as it's written—and we've acknowledged that, but in the framework for amendments we've made it perfectly clear that the bill does not

apply to unions. There will not be accountability imposed upon unions and it will not affect collective agreements.

The Chair: Mr Hudak.

Mr Hudak: I think we all appreciate that the minister has written a letter. The concern is that it's going to be in the same sort of disappearing ink that his campaign platform was written in. I think you've got a right to be suspicious of the government's intentions in this area. They made all kinds of promises on P3 hospitals. They made all kinds of promises about what this bill was going to be about. Once you open up the pages and look into it, there is a tale that is going to be all motherhood and apple pie in this legislation, but when union leaders, hospitals, doctors and nurses saw the bill on their desks, there was a whiff of something but it wasn't apple pie.

There is a hidden agenda in this bill that this committee has cottoned on to and we're actually going to see scores and scores of amendments. We haven't actually seen anybody who likes this bill. The only group that likes this bill are the printers, because of all the amendments they're going to be printing in the next couple of weeks. Let me ask you, why do you suppose the government brought forward this kind of legislation and described it as something entirely different from what CUPE and other groups have brought forward to be the true impact of the bill?

Ms Maldonado: Because I'm standing here representing 3,600 people, I'm afraid I can't answer that question honestly.

Mr Hudak: No problem. I didn't want to put you in a difficult spot. Given your conversation with the parliamentary assistant, there seems to be a level of distrust about what exactly the intentions of the government were with this particular bill.

Ms Maldonado: If this government was my boyfriend, I would have dumped him a long time ago.

Mr Hudak: In fact, the particular issues you've brought forward—and my colleague Mr Klees brought forward a motion to immediately bring those into the bill to protect collective agreements, in Sault Ste Marie, I believe it was. It was voted down by the Liberal government members. So until we actually see this brought forward, the real amended changes, I'm going to remain very suspicious about what this government's intentions were and why the description of the bill bore no resemblance whatsoever to what is actually in it.

The Chair: Thank you for coming, Ms Maldonado. We appreciate your input.

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CLEMENT BABB

The Chair: We have two people coming forward in a row who are individuals. As a result of what transpired at the subcommittee, we said we would give individuals 15 minutes for presentations. This will be a 15-minute presentation, Mr Babb. You've got that time to use as you see fit. Any time that is left over from the presentation we will split among the three parties.

Mr Clement E. Babb: Good afternoon. My name is C.E. Babb, from Burlington, Ontario. I'm essentially going to read my presentation to you. I want you to know that I am representing myself and not a group.

One comment: I am greatly concerned about the title of the act, the Commitment to the Future of Medicare Act. Reference to the future is an escape from that which is before us today. We must have sound health care now. We, the people, don't need promises for the future of health care, of medicare. What do I recommend? The Commitment to Sound Health Care Act.

Number two, I want to talk to you and caution you about the first part of the bill, the Ontario Health Quality Council. I recommend that this part be deleted from the bill. Why? Because the Ontario Health Quality Council sounds too much to me like predecessor activities which have borne little or no fruit.

What do I mean here?

Number one, the National Forum on Health of the 1990s was a complete bust and waste of time and energy, an effort undertaken because the Chrétien government, including Health Ministers Dingwall and especially Allan Rock, wouldn't and couldn't knuckle down and take action about health care across the land. This worthless effort was shut down suddenly, after three years, because of an election, so there was no payoff.

The Romanow commission was another bust in my opinion—and mine alone—with \$15 million spent over 18 months, between April 2001 and November 2002. What's the legacy? In my opinion, nothing. Well, not exactly. The legacy is the illusion of leadership, of action, of decision. Yes, Romanow did a magnificent job. He consulted, researched, listened, talked and produced solid reports. But what's been done? Nothing; just meetings, conferences and the like. More and more planning; more and more planning.

Just the other day was the meeting of the Premiers out west—they yakked about health care, among other things—and this summer they and federal leaders will get together again on health care.

Then there's the National Health Council, chaired by Michael Dechter. This has an annual budget of \$10 million. This group has met and then will issue a report annually, just like the Ontario Health Quality Council is supposed to do. What I am afraid of, with Bill 8's Ontario Health Quality Council, is that this high-sounding concept will engender more and more delay and will permit present and future governments, when faced with a difficult issue, to say, "Well, we'll get to that, but first we have to wait till the council completes its report, which, by the way, will be completed six to eight to 10 months from now."

Please do not let this piece of legislation continue delay after delay, study after study, annual report after annual report. Smitherman and McGuinty need to get on with it. Provide sound health care now, not in the future.

The Chair: Thank you, Mr Babb. You used up about five minutes, so that leaves us about three minutes for

each of the parties to ask you questions, starting with the government side.

Ms Smith: Thank you, Mr Babb. We appreciate your taking the time to come and speak to us. I was interested in your comments about the Ontario Health Quality Council and the National Health Council. One of the things we've provided in drafting this legislation and creating the Ontario council was to ensure that we have one member who is also our appointee to the national council, so that we know what they are doing and there is no duplication; that they actually are complementary. Do you think that's a good idea in creating the council?

Mr Babb: That presupposes that there is a validity and a worth to the National Health Council. I, for one, don't think there is. I have to amend that and just simply say, yes, there are probably some good things that can and should be done, but I don't want to see those things done at the cost of simply getting on with it, organizing health care. That's what ministries and departments and all that kind of stuff are for. Why the hell do they need to go off to some retreats and conventions and meetings and all this kind of stuff? Their job, your job, the ministry's job is to provide health care. I give you my money—my neighbour Willard gives you my money—and you're supposed to do something concrete with it, not fart around on a bunch of conferences and councils and this kind of stuff.

Ms Smith: I think the Minister of Health would agree with you. In fact, he gave a speech two days ago where he spoke about the Romanow report and the various studies. He said, "The Romanow report has set out, in clear and compelling terms, what our health care system needs. It's time to take the necessary steps to get us there." He outlined in his speech a number of steps that we're taking to reform our health care system. I'll make sure you get a copy of this speech before you go, because I think it will give you some comfort that action is being taken on a number of fronts.

Mr Babb: Thank you very much for offering that. I must tell you that on the Monday before, I tried and tried to find out where the minister was making his speech, about six telephone calls, and nothing happened. Nobody was able to tell me when and where, and I learned after the speech was over that it was held at the Economic Club, wherever that was.

Interjection.

Mr Babb: Sixty-five? That's OK. I would have a way of getting in and just listening, I'm sure. Or 65, it would have been worth it.

Ms Smith: I understand. Well, I'll get you a copy of the speech. I think my colleague, Ms Wynne, had something else she wanted to add.

The Chair: You've got about a minute.

Ms Wynne: In every sector that we're dealing with right now, there's a lack of a plan, and there's a lot of fracturing that's gone on. The Ontario Health Quality Council is an attempt to get a handle on what's going on, report to the public and move forward. What would you do in order to get a handle on some of those issues, set

some standards and hold institutions accountable? How would you do that?

Mr Babb: You're talking about setting standards in the future?

Ms Wynne: I'm saying setting some benchmarks, setting some goals, holding institutions accountable right now, because the money Mr Smitherman announced this week is going to be tied to some accountability measures. How would you do that, if not through having some body that was doing the thinking about that?

Mr Babb: I would think that body would be the Ministry of Health. Good grief, there are a gazillion people on the staff there. You've got thousands of qualified people.

Ms Wynne: So you don't think it would be helpful to have people from the community and folks who are close to the grassroots having some input into that?

Mr Babb: Why do it now? Why not do it before?

Ms Wynne: We weren't in power before.

The Chair: We're going to go to Mr Klees.

Mr Klees: Sir, your point is very well taken. Ms Wynne says, "Wouldn't you want to have some people from the community involved in accountability?" Well, we have that now. It's called the board, first of all, at the local community level, volunteer people from all sectors of the community who sit on boards of hospitals, the very boards this bill is undermining. We've heard from chairs of boards here who have said to this committee, "If this bill goes through, you will have a resignation from every member of the board, because what you're doing is giving the authority to the minister to reach through the board and to basically take single-handed control of everything that goes on in your local community hospital."

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Then, in addition to that, as you so well put it, there are the thousands of employees of the Ministry of Health, and what are they doing? The question we've asked around this committee table is that with all of the accountability you want to drive down to the hospital, where is the accountability measure for the Ministry of Health? What are they doing with their time? And what is there in this bill—not one single sentence—about how the minister or the ministry are going to be held accountable to the people for their role in ensuring efficient, effective and quality delivery of health care? I'd be interested in your comments on that.

Mr Babb: I have too many, but I just think that's a big rub. To me, accountability of the ministers—Wilson, Clement etc—has been horrible. I don't know exactly how it can be done, but certainly not an inquiry, certainly not a commission.

Just a couple of things: When Romanow and Allan Rock came off the Hill down to the National Press Club in 2001, I was there yelling at the guy, "All you're going to do is delay, delay, delay." So he went in and so forth. On the day, November 27, when he did the same thing and came out of the press club after he'd finished delivering his report, I was that old fart standing there, "Delay,

delay, delay,” and he said, “It’s up to you,” meaning it’s up to the public. It’s not up to the public; it’s up to the politicians to get cracking on health care.

The Chair: Ms Martel.

Ms Martel: Thank you for being here today. I expressed my concerns with respect to the health quality council in an exchange I had with the minister when this bill was introduced. I said to him my concern was that it was going to be a body with reports, like many others, and nothing will be done. Cancer Care Ontario—I’ve used this example before and I’m going to use it again—issued a report in 1999, or the Provincial Auditor did, that said treatment for cancer should be done in four weeks, and we still aren’t meeting that objective. That was 1999. So I’m not very interested myself in having a report produced that is just going to have a bunch of recommendations that never get implemented. That’s the first thing.

The second thing—and Ms Smith, the parliamentary assistant, is going to correct me if I’m wrong in this at some point in the afternoon, but I think this is what she’s talking about when she says the minister, in his speech, talked about what the McGuinty government has already done with respect to going forward on Romanow. She’ll correct me if I have the wrong paragraph, but I think it’s the right one:

First, “We have quickly moved to redefine our relationship with the federal government on the basis of co-operation, and we played a key role in ensuring the establishment of the National Health Council.” So what?

Then, “We appointed Dr Sheela Basrur as Ontario’s chief medical officer of health and now all Ontarians will benefit from her remarkable abilities as she leads the renewal of public health in our province.” I think it was interesting when they appointed her that they did not also say, as they promised in the election, that they would make the chief medical officer of health’s position independent of government. She’s not, and now she’s an assistant deputy minister, so I sure hope she’s not going to be co-opted by the bureaucracy.

Third, “When a Toronto hospital discovered a problem with the sterilization of medical equipment, I directed all hospitals to conduct an audit of infection control practices. A process that brought cultural change to hospitals.” You’ll note what the minister didn’t do was pass a regulation so that ministry inspectors can go into hospitals and actually independently audit their process of sterilization, nor did he provide any additional funding to hospitals for infection control practitioners, despite the recommendation for that in the interim SARS report that was released in December, a report that was commissioned by the former Minister of Health.

Fourth, “We’ve taken decisive actions to protect our seniors in long-term-care facilities by conducting unannounced annual inspections. And my parliamentary assistant, Monique Smith, is conducting a top-to-bottom review of long-term care to make the system more transparent and responsive to the needs of our seniors.” I wish, with respect to long-term care, the government

would just go forward and put back the standards that used to be in place in long-term-care facilities; standards, for example, of having a nurse 24 hours a day, seven days a week, having a regulation with respect to the minimum hours of care—it was 2.3 when we left government; the Tories trashed that, and now there is no standard—or even put back a regulation to say that people in a nursing home will get a bath once a week, because there’s no regulation with respect to that right now.

So I appreciate the review, but I’d really like to see the regulations that could be passed at cabinet on a Wednesday morning to ensure that we have standards, regulations, for quality of care.

If I read the wrong part I’m going to be corrected, but I just thought I should make a point of saying that in terms of the health care issues that are facing us, that’s a pretty short list. I don’t see much change there.

The real problem I have is that if you look at the preamble that talks in glowing terms about health care, it’s great, but when the rubber hits the road, there’s nothing in the bill that, for example, changes home care, ends competitive bidding or even puts more money in, despite the Liberal election promises. There’s nothing that talks about pharmacare for catastrophic drugs, to put that into place. And there’s certainly nothing, and I’ve said this over and over again, that ends private sector involvement in health care, like getting rid of the P3 hospitals, getting rid of competitive bidding in home care or getting rid of the private, for-profit MRI clinics. So there’s a big disconnect between the preamble and the rest of the bill.

The Chair: Thank you, Mr Babb, for travelling from Burlington to see us today.

HENRY BOSCH

The Chair: Our next delegation is also an individual, Henry Bosch. Make yourself comfortable. Welcome. The same rules apply: 15 minutes to use any way you choose. Any time that is left over we will split among the parties. If you could identify yourself for Hansard, that would be great.

Mr Henry Bosch: Thank you for inviting me to speak here today. My name is Henry Bosch and I am a paramedic in Niagara. I am also the vice-president of the Ontario Council of Hospital Unions representing southern Ontario.

I have read Bill 8 and I am alarmed at what I read; specifically, the accountability section, part III. In this section you call for the employer, known as the service provider, and the bargaining agent or entity, known as the union, to enter into accountability agreements or face fines of anywhere up to \$100,000. You are in fact asking both the employer and the union or bargaining agent to police each other to keep the hospital fiscally responsible. This is not the role the two entities were ever set up to do. They are for service delivery and quality assurance; that is, we deliver professional services to the public so that the public gets the type of health care it deserves.

In your Bill 8, you give the Minister of Health the appearance of ultimate power. By this I mean that he or she can issue an order of compliance, mainly based on fiscal responsibilities, and is neither liable nor accountable for his or her actions. We, the public, see this as an abuse of office.

Your government seems to try to equate a balanced budget and debt reduction to equally accessible health care. The health and welfare of Ontarians should not be attributed to dollars saved. Health care over the years has been slashed and reduced to near bare bones, and now your government, in the guise of Bill 8, is looking to allow many services now delivered publicly to be delivered by private, for-profit companies.

I find it hard to listen to the money angle. By this I mean that you claim hospitals spend too much of the public taxpayers' money and that your government feels that most hotel services, as you call them, in hospitals can be provided by private, for-profit companies, and thus save the taxpayers money and somehow reduce the debt. I don't quite see how a private company doing the work of the public sector can be cheaper. We all know that every contract has a built-in profit margin.

That leads me down another path. For example, if it costs the government \$1 million to provide a service in a hospital and you are able to contract it out for \$900,000, it would appear that you have saved \$100,000, but I ask you, at what cost to the health care service? As we all know, you need to factor in the profit margin of approximately 15% to 20%. So we are only looking at approximately \$700,000 to \$750,000 to provide the service at the same level as the public sector.

If I can, I'd ask you for a moment to recall Bill 29, introduced and passed in BC, which closely resembles your Bill 8. In that instance, the services contracted out are leading to an increase in infection rates in hospitals and a decrease in cleanliness of hospitals, becoming totally unacceptable and bordering on absurd.

Even at present levels of staffing in the hospitals in Ontario, the SARS epidemic of last year was overwhelming on staff, as well as resources in the health care sector. So imagine, if you will, that the services in the affected hospitals were being delivered by the private sector. I will let you draw your own conclusions.

Bill 8 essentially lets all these concerns addressed previously become closer to reality, and all at the cost of health care to Ontarians.

Your Bill 8 speaks of making health care facilities in Ontario fiscally responsible. I am quite certain that you could poll the people of Ontario and ask them one thing: Would you like to see the provincial government use your tax dollars to bring down or lessen the debt or would you like to see your tax dollars spent on accessible health care, education and other public services? I think they would choose the latter.

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To champion for a debt-free province at the cost of public sector services is wrong, but to try to introduce legislation such as Bill 8 to try to achieve this is not acceptable. I think all Ontarians would agree that some

sort of accountability in the health care sector is needed, but to try to take it out of the pockets of some of the lowest-paid employees in the hospitals by a form of union-busting is unacceptable.

I am not sure if you know this or not, but most people who enter the health care field in some capacity, be it housekeeping, dietary, clerical or even nursing, do so to embark on and make it their career. The wages, benefits and pensions are structured so as to make the health care sector a viable and sustainable career, not a stepping stone to something else. If Bill 8 is passed and not amended, you are paving the way for private health care service delivery.

Please amend Bill 8 to reflect the comments and concerns you are hearing in these public hearings and also those concerns of the unions, doctors and other agencies that daily deliver health care. Thank you for listening.

The Chair: Thank you very much, Mr Bosch. You only used up about six minutes, so that leaves about three minutes for each of the parties. Our sequence this time begins with the official opposition.

Mr Hudak: Thank you, Mr Bosch, for your presentation and your concerns about Bill 8. I apologize that I missed the opening. The part I caught was dedicated to public health care as opposed to private involvement in health care.

My recollection was that the then campaigning Liberals, now governing Liberals, made some very strong comments about eliminating private care and closing the door to private care. Do you remember them making promises like that, and how did you interpret that as a voter?

Mr Bosch: I remember hearing it from Campbell, McGuinty and Charest, and in all three of those provinces right now they're having a problem with private coming in and trying to do the work of the public sector in health care, education and stuff like that. So yes, I did hear it but I don't see it. I read the bill. Like I said, the first part is nice, and then the further you get into it, the way I see it, it paves the road for private, for-profit companies to come in, and I don't see how you can still offer the same level of care at a lower rate.

Mr Hudak: It's your recollection that McGuinty at the time had said he was not going to have private health care in Ontario. How does this bill gel with what you saw as McGuinty's campaign promises?

Mr Bosch: It doesn't.

Mr Hudak: It's sort of the opposite.

Mr Bosch: Yes.

Mr Hudak: In terms of private care, do you see any role in the health care system for private provision of care or are you positioned against it in its entirety?

Mr Bosch: I would have to look at which section you're talking about, but mainly the core services that hospitals and health care provide should be provided by the public, because it is public money. Why should someone make a gain off my tax dollars when I'm paying for

what I thought was a service? Like I said, being in health care, I've noticed it go all the way down to bare bones.

The Chair: Ms Martel.

Ms Martel: Thank you for being here today. You referenced compliance directives at the start of your remarks. Do you want to tell me what your concern is in that regard?

Mr Bosch: They alluded earlier that these compliance directives and accountability agreements won't affect current collective agreements. I have a problem with the fact that it could be imposed upon you down the road: "You're not complying with this, so we're going to come in and make you comply."

When you look at the thing, it says there that even if the Minister of Health comes in and signs an order, 28(a), I believe it is, says that it's mutually agreed upon by both parties. In the health care sector, if you want to save money, if the hospital is trying to become fiscally responsible, that's what collective bargaining is. We fall under HLDA, so we're at the mercy of the binding arbitration process, and that's how we feel we can get it. We go through redeployment and stuff in other ways and that's how they make their budgets. We fight with them to make their budgets at the end of the year, but it shouldn't be up to us to please them. The government shouldn't have the ultimate power to come in and say, "We're now going to tell you where you're going to cut." Usually it falls on the backs of the lowest-paid workers, because they usually get the service in the clerical end first. That's the problem there.

Ms Martel: Yes, we've heard from people that it's usually not upper management that might have to take a cut in pay.

Mr Bosch: Yes, there is that possibility too, but I haven't seen much happen in the last 19 years.

Ms Martel: So your concern really has to do with the arbitrary nature of it, that there doesn't seem to be a whole lot of room for negotiation if you look at the bill and you see in so many sections that the minister has the power to do anything, at any time, anywhere, and for any length of time as well. I can tell you, there isn't much of a change in that with respect to the proposed amendments that the minister has put forward either.

Mr Bosch: I just saw them now, when I came in. I'll look at them more closely, but just looking at the front, it doesn't seem to even address half the concerns of health care.

The Chair: Ms Smith.

Ms Smith: Thank you, Mr Bosch. We appreciate your being here. I'm sorry to hear that you hadn't seen the proposed amendment framework. The minister, however, has made it clear in a number of addresses and in a letter to Sid Ryan of CUPE that the accountability agreements that we're discussing do not apply to trade unions, they will not be required to enter into them, and the collective agreements will not be affected by them.

I was interested in your comments that this bill reflects Bill 29 in BC. I don't know how familiar you are with Bill 29 from British Columbia, but I just wondered how

this bill in any way reflects things like right to reorganize, service delivery, multi-work-site assignment rates, contracting out outside of the collective agreements, employment security and labour force adjustment agreements, health care labour adjustment society, layoffs and bumping, what parts prevail over collective agreements. Are there any things like that addressed in this bill that you've seen?

Mr Bosch: No, it's quite the opposite, actually. It says that they can come in—like I say, with a compliance order he can strip collective agreements. That is the way we read this.

Ms Smith: I've actually seen the legal memo from Sack Goldblatt Mitchell; I think that's what you're referring to.

Mr Bosch: Yes. I've got it here.

Ms Smith: In fact, it doesn't say that this bill will allow you to strip collective agreements.

Mr Bosch: There's the possibility.

Ms Smith: It's even more couched than that, and I think that is a stretch of an interpretation of this bill. This legal memo—it's not an opinion—was provided prior to the amendment framework and prior to the minister's stating that unions and collective agreements would not be affected by this bill. I'm not really sure that it can hold water. I wonder why you feel so strongly that this bill reflects the situation in BC.

Mr Bosch: On the side of the contracting out, what Bill 29 allowed the government to do there was to come in and carve out collective agreements, carve out sections. Laundry was privatized. What they did was people were offered jobs back, and the jobs they were offered back were at \$9 an hour with no pension, no benefits. That's why I allude to that most people who enter health care enter it to make it their career. At that point, in BC, in the hospitals affected, Kelowna and all that—that's happening is, it's a stepping stone for another career now, and that's why I referenced there that the infection rate and cleanliness are going down, because you're only going to get what you pay for. That's why health care professionals, be it the service side, the clerical side, or the professional side, all do their jobs to make it a career. I believe it was two and a half weeks ago that the doctors pulled out of Nanaimo.

Ms Smith: Have you seen a copy of the letter to Sid Ryan from the minister with respect to the bill?

Mr Bosch: No.

Ms Smith: I'll make sure you get a copy of that before you go.

Mr Bosch: It's probably at home. I'm on that same mailing list.

The Chair: Thank you, Mr Bosch. The time has expired. We do appreciate your being here, and your input this afternoon.

I'm going to let Mr Craitor introduce the next delegation.

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**ONTARIO CHIROPRACTIC ASSOCIATION,
NIAGARA FALLS CHAPTER**

The Acting Chair: The next presenter is from the Ontario Chiropractic Association, the Niagara Falls chapter. We have Dr Ted Mangoff and Dr Joanne McKinley. Good afternoon. You have 20 minutes. Any time that's left over will be divided between the three parties to ask you questions. I have two names here, so maybe you could just introduce yourselves as you speak so we could have that for Hansard. Whenever you're ready, go right ahead.

Dr Ted Mangoff: Do you want to do introductions?

The Acting Chair: Why don't we do that and then we'll have it officially in Hansard.

Ms Patricia Dziarnowski: Patricia Dziarnowski.

Ms Kim MacGregor: Kim MacGregor.

Dr Mangoff: I want to take the opportunity to thank the Chair and the members for allowing us to appear today. I understand you've already met with a couple of members of our profession so hopefully I won't be repeating a lot of their information.

Basically the reason we're here today is, first, to reiterate the need for chiropractic inclusion in the proposed bill that's under current consideration and for any changes that are proposed for the health act like accessibility.

The second thing is to establish a commitment on the part of the government to ensure continued access of chiropractic care to the public at large and to maintain it as a component of the Ontario health care system.

Third and most important, we want to present input on the value of these services from a patient's perspective and how any barriers to care that currently exist affect our patients.

There are just a couple of points I wanted to make about doctors of chiropractic. We serve a large and growing population in the province. I believe about 15% are currently under chiropractic care and over 50% have at some point consulted a chiropractor.

We do provide safe, effective and evidence-based care with a high degree of patient satisfaction and value. As well, we provide good value for the dollar. Chiropractic care costs are a lot less relative to the traditional medical stream, such as a hospital or family physician. So those are a couple of the points.

Care has consistently provided a quick return to work as well as return to normal activities of living, so we do have effective treatments and I believe can aid the government in saving some money in that respect.

Most of these points have already been cited in some ministry studies such as the Wells report and the two Manga reports. Those were conducted as late as 1993 and 1998.

To hit home with this, we want to make sure that chiropractic is included and that access to care is maintained for the public in Ontario.

I just wanted Joanne to address a couple of points on accessibility and then hopefully hear from the two patients we brought with us today.

Dr Joanne McKinley-Molodynja: Thank you for letting me address the committee also. I'm here because accessibility within my practice is of particular importance because I'm located in a low- to mid-socio-economic area. It's a real barrier for patients to access care because of the lack of funding. I don't know how many of you know that OHIP pays \$150 per year, from April to the end of March. That's \$11.75 for the initial visit and then \$9.65 for subsequent visits. That's about 15 visits a year. We are allowed to charge a fee on top of that. If you have a patient who comes in with an acute condition, that small amount, \$150, can be used up quite easily and then they're responsible for the extra charge. If they don't have the financial resources to cover that, then as a practitioner you have to decide, "I'm going to make special arrangements for that patient," but you can't do that for everyone. That leaves them with the option of seeking care elsewhere.

What do they typically do? If they have even come to your office in the first place, if they can afford to come and then they have to stop care, they're going to go back to the family doctor. They may go to the emergency department. If they're on Ontario Works, they may use the Ontario drug benefit program. But these are all extra costs to the system that could have been absorbed a lot cheaper if they had stuck with the chiropractic care, if it wasn't such a huge barrier to them.

Another thing they might choose to do is do nothing. If they're a working person, they're going to miss time from work; they're going to be less productive. It's just a huge waste of human resources.

The future of medicare has got to include chiropractic care. Like Ted mentioned, there is the Manga report that has shown how cost-effective it is. It's kind of hard to understand, when the government has done studies that show how cost-effective it is, why it's not going to be included from the get-go.

I've brought two patients, Pat and Kim, who have been with me and have definitely had economic barriers to care. I just want them to go over their stories.

Ms Dziarnowski: Joanne has offered me six months' free chiropractic care for my presentation here, so that is very generous of her and I appreciate it. Seriously, I had a whiplash injury at the age of nine that was left untreated and I've had problems with my neck and shoulder as an adult, so I've been using chiropractic care for quite a number of years.

The fees charged above OHIP have been a hindrance to me on a couple of occasions, one when I exceeded the maximum yearly amount and then another when my husband was unemployed. I was only able to continue treatments because Joanne waived the fee until I was able to make the payments myself.

I chose to go that route and try and maintain my own health rather than resorting to drugs and going to my family physician. I would also use other alternative ther-

opies if there was some funding or partial funding available through medicare. I believe allowing individuals to choose lower-cost alternative therapies like chiropractic care by providing better funding would ease some of the burden on the present health care system and benefit everyone.

Ms MacGregor: I'm Kim MacGregor. I came to Joanne because of some back, hip and foot problems that came about from my pregnancy. I was unable to get out of bed in the morning. I had pain every single day. I couldn't go for walks, I couldn't lift my daughter and, more important, I was really limited because of that in my job opportunities. I'm a daycare worker and I have to lift children all day long. That presented a big problem for me. I actively pursued alternative care. My goal was to avoid being medicated, X-rayed or possibly have surgery. I've been able to do that through Joanne, through corrective and preventative chiropractic care. By doing that, I feel I've saved the province a lot of money. I was in a lot of pain. It was very difficult to get around and Joanne helped me with that.

I now have increased mobility. I can go for walks pain-free and this has made me a more productive and viable employee.

I believe medicare should include chiropractic care. I believe modern medicine should be about choices and I don't feel those choices should be taken away from me. If chiropractic and other types of alternative care are not included, those choices will be taken away from me.

I'm a single mother and I'm laid off. I have no financial resources to sustain chiropractic visits on my own. Limited funding has been a financial barrier. I've hit that limit, as we've heard from Pat, and I had to suspend my care for a while. But through Joanne—again, she's given me a break in the fees.

Also, not everyone can be as lucky as I to have a Dr Joanne in my life. She's literally given me the shoes off her feet so that I could have proper foot care for walking, which was part of my care. She did that; she gave me her shoes.

Interjection.

Ms MacGregor: I could cry. She's been a wonderful help to me.

Dr McKinley-Molodynna: I have to tell you what happened. I'm a runner, and when my running shoes are no good for running, they're still good for walking. So I do that.

In closing, these are people who have come to my office and that's great and I can give them a break, but, as I said, we can't do that for everybody. There's a huge percentage of the population that is not even coming into our office for the kind of care that we can provide that's cost-effective because it costs them money. That's maybe the whole fault of the way people look at their health care and what they're responsible for. But, yes, there is this true financial barrier. Inaccessibility because of finances really needs to be looked at.

The Acting Chair: Thank you very much. We have six minutes left. Starting with Ms Martel from the NDP, you have two minutes.

Ms Martel: Thank you for being here today. There are probably two points: (1) that you don't appear in section 10 of the bill, which would lead you to assume that you don't appear anywhere in terms of priority in the health care system; and (2) full coverage, by OHIP essentially, for chiropractic care. Let me just deal with the two of those.

You should know that that section of the bill, part II, actually came from a previous act. It was even in place before I got here, and I got here in 1987. So this goes back to 1986. Essentially, that whole section 10 was lifted from that previous act. I can't explain to you why all the other regulated health professions were not included at that time, but you shouldn't take from that that the ministry and the government are somehow cutting you off from participation in the health care system.

So there certainly has been a suggestion that we can either (1) change that section so that we don't list any of the health care professionals, or (2) change the whole section and include all of the regulated health care providers, which should be about 21 or 22, so that everyone sees that they are listed and can enter into agreements with the government. I'm not sure where we'll end up on that in terms of what amendments might come forward, but clearly something has to be done so that the regulated health professionals don't think they are excluded for some reason that they can't understand any more.

Second, with respect to the broader issue of full OHIP coverage for chiropractors, that is a big issue. It's a significant funding issue, and I wouldn't pretend to tell you that this committee has grappled with that, because we really haven't. I wouldn't expect that it would be something that would come forward through this bill. So I think the most that we can tell you is that the current situation will not be changed in any way, shape or form in terms of the current relationship. What that relationship will be in the future, especially in terms of funding to deal with the barriers to access, is a question that I just can't answer for you at this point in time, but it is very legitimate. We've had good presentations. We got summaries of the reports that you referenced in one of the other presentations so we could understand the cost-effectiveness and the reality around that, but I don't know where that broader discussion will take place and how it will end up, to be honest with you.

1510

The Acting Chair: Ms Wynne.

Ms Wynne: Thanks for coming here today.

Actually, as Ms Martel said, we have heard from the chiropractors on this issue and we understand. Just so we're clear, subsection 10(3) deals with the possibility of the minister entering into agreements with other groups. So not only are you not excluded in this language, but there's every possibility that you could be included. So it really does come down to that issue of, "Are we going to list everybody? Are we going to change that language in a bunch of different places in legislation?" Maybe that's where we have to go, but that's not what we've done here and that doesn't exclude you.

The Lieutenant Governor in Council may make a regulation providing that the minister may enter into an agreement under subsection 10(1) with a specified person or organization other than an association mentioned in subsection 10(2), so it's absolutely possible that you would be included in that section. That's the best we can say at this point. It's not exclusive, but it's not as inclusive as you would like it to be. We understand that.

Did you want to comment on it?

Dr McKinley-Molodynja: Considering we're the third-largest provider of health care—

Ms Wynne: I know. I understand. I love my chiropractor.

My colleague has a question.

Mr Shafiq Qaadri (Etobicoke North): Actually, it's more of a comment.

First of all, as a family doctor myself, I think really the model that we in the government are attempting to adopt is one of collaboration, co-operation. Frankly speaking, in respect of the patients you've brought, which is great—it really brings this story to life—we family physicians are really probably too busy and overwhelmed. As you know, there's something in the order of about a million Ontarians without access to a family doctor. So I think we in the government very much appreciate and value the contribution of your members, the Ontario Chiropractic Association, on a shared care model for the betterment of the health of Ontarians. So thank you very much for your presentation.

The Chair: Mr Hudak.

Mr Hudak: Thank you, Dr Mangoff and Dr McKinley, and two patients and friends who made the presentation. It was a very good presentation—touching, as well, with the particular circumstances. I think it's great that you're here. You made a point about the bill. You think it's an important one that the government has responded to. I think it's important to continue to get your points on the public record, whether through these committee hearings—I know chiropractors on a regular basis meet with their MPPs. I encourage you to continue doing that. I know other professions have their own days at Queen's Park where they get a chance to interact with members of all parties about their particular issues.

A question for TC: Is that the Wells and the Mangoff report that you had referenced today?

Dr Mangoff: Close enough.

Mr Hudak: Maybe a bit down the road, eh? Just for the public record, maybe you could discuss a bit in terms of where you see chiropractic care not only maintaining strong quality in the system but saving the taxpayer dollars. Could you describe that a little bit? You started to get into it, but I think it's important to put it on the record.

Dr Mangoff: Joanne did touch a little bit on that. One of the things is that without proper access to our treatment—finances are one of the biggest barriers—where are they going to go? Generally, either they don't receive treatment at all and then the condition regresses or progresses to the point where they have time off work or

they can't care for family or whatnot; or, secondly, they are under care and midway through their care they run out of funding and they can't afford to continue on and they drop out midway, which will lead them, again, either to the emergency room or their family physician or no care at all.

Essentially, that is where the savings lie: If a person presents to the emergency room, the costs are a lot greater there than, say, the \$24-odd that we receive for a visit. Part of that is the OHIP funding, which is really \$9.65. So most of the patients in the office would pay a \$15 co-payment. There are a good majority who can't afford that, so they go into the medical stream, which is more cost-intensive. That's where you are spending most of the money. Looking at the productivity aspect of things, getting back to work sooner so that less time is lost, there is better productivity in that respect. That's where the costs are going to be reduced and that's where the savings are going to be found, as far as chiropractic goes.

The member did mention collaboration in the medical community. It would be excellent; we'd love that. We're starting to see a lot more of that over the last couple of years. I'd welcome referrals back and forth. It allows the medical doctor to do what they do best. It allows us to do what we do best. The patient gets better overall. So everyone wins, for the most part. That's where I see the most cost savings: in just allowing them to continue their course of care to completion, or entering it altogether.

Dr McKinley-Molodynja: To add on to that, just from a diagnostic point of view, because we are trained to identify biomechanical problems, and that's what most low-back—specifically, the Manga report talked about low-back problems. That's what we're trained to look at. If you go into a family physician's office, first of all, they are way too busy so they do a brief examination, typically, and then they may send you for an X-ray which you may or may not need. Often you don't need that X-ray. So that's another cost. Then, if they are not sure after that, there's a referral to the orthopaedic specialist, and that's another cost. There are a lot of costs that don't need to be incurred if you know where to go in the first place, if you know to go to the chiropractor if you've got that type of back pain.

The Acting Chair: Thank you very much. We appreciate your coming out. On behalf of the committee, I appreciate your input.

NIAGARA FALLS AND DISTRICT LABOUR COUNCIL

The Acting Chair: The next group, for 3:20, is not here, but the 3:40 group is here. That's the Niagara Falls and District Labour Council, with Julius Antal, who is the president. You have 20 minutes and, time permitting, there will be an opportunity for each of the parties to ask you questions.

Mr Julius Antal: By way of introduction, my name is Julius Antal. I am the president of the Niagara Falls and

District Labour Council, representing 2,700 workers from 24 affiliated unions representing workers from all walks of life, including the medical services staff. We have long been involved in economic and social issues in our community, such as health care, and welcome the opportunity to speak. I'll try to move along rather quickly so that, if you have any questions, I may be able to direct some answers.

Bill 8, titled the Commitment to the Future of Medicare Act, was introduced last November to fulfill the Liberal Party's promise to the people of this province to enshrine the Canada Health Act in Ontario law, to create a health quality council to measure the effectiveness of health care and to ensure accountability and prohibit a two-tier system.

1520

We do not believe that this bill, as it is currently written, enhances a universally accessible, publicly funded health care system based on the principles of accountability, transparency and accessibility. Our intention is to proceed through the major sections, pointing out weaknesses and offering our views for change.

The preamble recognizes that our system of publicly funded health care services reflects fundamental Canadian values and that its preservation is essential to the health of Ontarians today and in the future. It confirms the enduring commitment to the five principles of medicare: administration, comprehensiveness, universality, portability and accessibility, as currently codified in the Canada Health Act.

Unfortunately, there is little in the actual legislation that provides significant new initiatives to these principles. Although the preamble commits the government to support the prohibition of two-tier medicine, extra-billing and user fees, a closer examination of the legislation shows it fails to entirely close such options. While the preamble recognizes that pharmacare for catastrophic drug costs and primary health care based on assessed needs are central to the future of the health care system, there is nothing in the draft legislation that directly addresses either of these concerns.

The Ontario Health Quality Council outlined in part I, sections 1 to 6, of Bill 8 is supposed to (a) monitor and report to the public on access to publicly funded health care services, health human resources in publicly funded health services, consumer and population health status, and health service outcomes, and (b) support continuous quality improvement.

Given the preamble's commitment to the principles of the Canada Health Act, we find it alarming that the Ontario Health Quality Council does not include reporting on the extent, or otherwise, that the Ontario health care system complies with the principles of public administration, comprehensiveness, universality and portability as contained in the Canada Health Act. Further, it is not required to report on issues relating to two-tiered medicine, extra-billing and user fees. Each one of these issues is fundamental to the health care system and of primary importance to the public.

The council is to be composed of between nine and 12 members, all of whom are to be appointed by cabinet. For all the public knows, representatives from the private, for-profit sector could be appointed, using this to erode our public, not-for-profit system. It is our strong view that for-profit providers, given their blatant conflict of interest, should be excluded from this council.

We support an elected, inclusive and representative council that is free to make recommendations on the steps to be taken to ensure the future of Ontario's health care system.

Opting out and extra-billing: The section of Bill 8 extends the prohibition against extra-billing by eliminating the right of physicians and other designated practitioners to opt out of the Health Insurance Act and receive direct payments from patients for insured services up to the OHIP maximum. These provisions in subsection 9(2) seem to strengthen the prohibition on extra-billing and opting out. Yet a further subsection of the bill, 9(4), contains language that may well open up the possibility for the government itself, through regulation, to allow extra-billing and opting out. We cannot leave such an important issue to be decided by regulations that may be passed by cabinet with little or no public input.

Queue-jumping: Here Bill 8 proposes a new section, section 15, limiting the ability of individuals to jump the queue. In this respect, an insured person cannot pay to obtain better access to insured services, nor can a practitioner charge for granting better services to an insured person.

The main problem with this section is that it prevents queue-jumping for insured services only. Yet more and more pressure seems to be forthcoming, due to financial considerations and private interests, to delist services. As the list of medically listed services is restricted, this provision would not be applicable and those seeking delisted services would not be protected from queue-jumping. The major threat therefore is not the occasional queue-jumping abuse but rather the ongoing shift from public to private, for-profit health care services. It is our view that this shift must be stopped and reversed. The newly elected Liberal government campaigned against the privatization of health care and should follow through on its commitment to the people of Ontario.

Currently, the most insidious form of privatization is what is termed public-private partnerships, or P3s. The P3 projects of the previous Conservative government, from Brampton to Ottawa and others in the planning stages, should be immediately halted, along with the delisting of services. It has been estimated that such private models can be expected to cost at least 10% more than public sector equivalents. So in addition to the evidence from other such experiments in Britain and Australia that suggests P3 hospitals would include a deterioration of hospital services and diminished accountability, Ontario simply cannot afford a private health care system. Making the operation of a hospital private but keeping the ownership public through a mortgage doesn't substantively change the private, for-profit character of a P3 organization.

Already, private MRI and CT diagnostic clinics operate outside the public system and drain money from it through third party billings, such as WSIB and third party insurance, thereby depriving hospitals of lucrative revenue. Further, such private clinics have depleted trained personnel from our public institutions, creating opportunities for those with financial resources to leapfrog the waiting lists.

Home care provides a further example of the negative impacts of privatization. The privatized delivery of home care through competitive bidding adopted by Ontario is redirecting precious health care money out of patient care and into ballooning administrative costs, and this despite sending labour costs and people's living standards into a nose-dive. Ontario's home care system is rife with duplication, inability to utilize staff efficiently and additional expenses surrounding tendering requests for proposals, preparing bids, evaluating proposals, monitoring and, of course, profit-taking.

Block fees: Many physicians across Ontario have charged patients for uninsured services by charging an annual or block fee. Typically, such services include telephone advice, renewal or prescriptions by telephone, completion of various forms etc. Such block fees have, to date, been largely unregulated, although there are significant guidelines outlined by the College of Physicians and Surgeons of Ontario.

The proposals in Bill 8 specify that the government, not the physician, will determine whether and under what circumstances block fees can be charged. It is our view that Bill 8 should simply ban the practice of block fees. It violates the principles of the Canada Health Act, as it creates a barrier to accessibility and is unnecessary, as physicians can charge on an item-by-item basis for uninsured services. A system that allows block fees is open to abuse, and patients compelled to pay these fees have limited options with the shortage of family practitioners, especially in our area.

Accountability agreements: The most important, controversial and potentially dangerous sections of Bill 8 are contained in part III, sections 19 to 32. They cover the powers of the Minister of Health and Long-Term Care to compel persons to enter into accountability agreements or compliance directives. These provisions have been drafted in such a broad manner as to give the minister unprecedented authority to require individuals and organizations to comply with ministerial initiatives. Potentially, these steps could override legal collective agreements or other negotiated agreements as well as labour legislation within the province.

Under the provisions, the minister can direct any health care provider or any other agency or person to enter into an accountability agreement with the minister and any one or more agencies, persons or entities. Even a trade union, under the broad definition of "health care provider," could qualify to enter into such an accountability agreement.

Not only is there little limitation on the minister's authority under such circumstances, but there is also little

explanation in the proposed legislation as to what accountability actually consists of. As defined in Bill 8, clause 19(a), an accountability agreement is an agreement establishing performance goals and objectives, service quality, accessibility of services, shared and collective responsibilities for health system outcomes, value for money and other prescribed matters. In short, an accountability agreement can cover anything the government wants it to cover.

We are opposed to sweeping powers being given to the minister and such undefined accountability agreements. Indeed, throughout the bill, the powers granted to the minister are too broad and open-ended. It is often unclear specifically what the directives are about; that is, their content and to whom they will be directed. As a person proceeds through the bill, one increasingly gains the impression that the directives of the minister can be to anyone for virtually any reason.

Further, according to section 20 of Bill 8, the minister, in exercising his or her powers, is to "be governed by the principle that accountability is fundamental to a sound health system," and is thereby to consider a list of matters such as fiscal responsibility, value for money, a focus on outcomes and any other prescribed matters. We are very much in favour of a high-quality health care system and desire value for money and fiscal responsibility as much as anyone, but terms such as these are all too often used as code words in the private sector. As representatives of the Niagara Falls and District Labour Council, we are committed to public health care and are opposed to such language if it is to mean advancing a privatization agenda.

1530

The sweeping powers of the minister and the breadth of the directives are further revealed in sections 26, 27 and 28. Section 27 enables the minister to unilaterally change a person's terms of employment and, if this isn't bad enough, "the change shall be deemed to have been mutually agreed upon," and, further along, "the change does not entitle the person to any sort of payment or compensation, despite any provision to the contrary in his or her contract or agreement of employment."

Section 28 gives additional unprecedented powers to the minister, enabling him or her to reduce funding, vary funding or discontinue any term of a contract or agreement of employment. Again, such dictated changes are deemed to have been mutually agreed upon.

These sections should be repealed in their entirety. They are in opposition to democratic practices, such as elections; transparency, such as public reporting on finances; increased community control; and any genuine accountability.

Under the provisions of part III of Bill 8, there is a distinct possibility of severe repercussions for trade unions and collective agreements. Trade unions and employers could be directed to address certain cost saving measures; for example, through collective bargaining. Should they fail to do so, they could face an order requiring them to reduce wages or benefits, or both.

Alternatively, they could be confronted with an order to repeal their no-contracting-out language or their successor rights clause.

In the name of value for money or fiscal responsibility, hospitals and health care employees could be compelled to consolidate operations such as laundry or food services and change their collective agreements to facilitate such changes. An alternative avenue open to the minister would be to simply order a compliance directive requiring collective agreement protections to be modified or overridden.

Admittedly there are counter-arguments to the misuse and unfairness of such a sweeping exercise of ministerial fiat, but why does the bill take us down this road when it is so obviously as undemocratic as it is unnecessary? Why should the vast majority of Ontarians who value public health care have to resort to counter-arguments to address the potential threat to free collective bargaining?

While the motivation of the government is not entirely clear, part III of the bill can only be seen as an attempt to grant the minister virtually unlimited power to unilaterally dictate fundamental changes in the health care system without procedural safeguards or democratic input, far less anything approaching transparency. Despite the comforting words of the preamble, Bill 8 is more reminiscent of the Conservative government's omnibus Bill 26 than it is of the five principles of the Canada Health Act. It even takes the further step in section 30 of seeking to insulate itself from legal liability arising from public opposition in the form of actions taken in connection with accountability agreements or compliance agreements. No one will be allowed to take legal action against the minister or the crown under the provisions of this bill upon its passage. At the same time, the government is free to prosecute anyone not complying with an order by the minister.

The powers and penalties in the bill are all stacked on one side, and it is not on the side of those who want democratic representation and transparency in a health care system supposedly designed for the people. Unfortunately, we are left with little alternative but to call for a complete withdrawal of this section of the bill.

In conclusion, an accountable health system must include: (1) democratically elected boards, open memberships and diverse representation on boards governing health care sectors; (2) whistle-blower protection; (3) transparency regarding delisting and defunding; (4) democratic governance of the OHIP list; (5) meaningful restrictions on commercial secrecy and full public reporting on finances within the health care institutions and sectors; (6) public consultation, meaningful input and public debate about changes to the health system; (7) full public disclosure of fees, service charges and other out-of-pocket costs; (8) duty of the minister to provide stable, multi-year funding; (9) representation of diverse populations on all boards and other governing bodies; and (10) meaningful input of health care workers and users at every level.

The threat to the future sustainability of medicare posed by private, for-profit corporations is critical. P3

hospitals will put billions of public funds in the hands of profit-seeking corporations for whom a veil of commercial secrecy obscures public scrutiny over profit-taking and misuse of public funds. In the endless search for new profits, corporations will seek new sources of revenue, imposing user fees and service charges wherever possible. The motivation and means for increasing two-tier health care are increased. The result is that the scope of services offered under the public system will be reduced. Beds and staff are cut, patients face new fees, two-tiering increases, public accountability and access to information is reduced, democratic control is reduced and costs rise, as well as executive salaries, as more of the health system is governed by profit margins and rates of return for investors.

The people of this province elected a government committed to outlawing two-tier health care in Ontario and stopping the creeping privatization of health care. This must also include non-clinical services and privatizing them in facilities. It must be made clear that medically necessary services include those services that support a patient's daily living, including food, laundry, maintenance, record keeping, diagnostics and therapies. We need to respect our sick and elderly and provide the best quality care possible.

The Canada Health Act calls for public administration of the health care system, recognizing the inherent threat posed by private insurance corporations. Similarly, private hospital corporations, private long-term-care corporations, private labs and private home care corporations are a threat to the future sustainability of Ontario's health system.

The current government ran on a platform of stopping the Americanization of our health system. The pre-election promise was very clear: opposing the creeping privatization and commitment to rebuilding medicare.

Any legislation purporting to show this government's commitment to the future of medicare must include concrete initiatives to roll back privatization and prohibit future for-profit control of our health care institutions. P3 hospitals must be banned. The private diagnostic clinics must be returned to non-profit hospitals. The tide of privatization sweeping across our health system must be stemmed. The future sustainability of medicare and the application of the principles of the Canada Health Act depend on it.

Privatization in the form of P3 hospitals is not reinventing government; it was the path rejected by the people of Ontario, and all the evidence from other jurisdictions tells us it will lead to far worse public services. We urge the government of Ontario to reconsider this bill.

Thank you for allowing me to participate, and hopefully I have still left time for some questions.

The Acting Chair: Unfortunately, you didn't. Your presentation was right on track, exactly 20 minutes. We appreciate your comments. They will certainly be looked at by all of us.

For committee members, we're going to recess for five minutes, and then the 4:40 group will be able to present. Then we'll go back on track after that.

Mr Antal: Mr Chair, may I have maybe 30 seconds? There was one issue I wanted to—

The Acting Chair: You can have 60 seconds.

Mr Antal: The question kept arising about the collective agreements and the new amendments to the agreements. Being from the private sector, we have found that any legislation needs to be strengthened in order for some of the things that are being put forward to work. I come from a plant that closed a year ago. I'm still working there, even though it's closed. It's a publicly traded company. Without giving power to the labour board to actually make commitments and decisions on the livelihood of workers, we need to button down every word within any legislation that is proposed. Thank you.

The Acting Chair: That will be looked into. Thank you very much.

**ONTARIO ASSOCIATION
OF SOCIAL WORKERS,
NIAGARA BRANCH**

The Acting Chair: There's a change of plans. The 4 o'clock group is here, so we're going to continue on. That is the Ontario Association of Social Workers, Niagara branch, John Stob.

Mr John Stob: There's no waiting around here.

The Acting Chair: Thank you very much, John. The process is that you have 20 minutes to speak, and if there's time left over after your presentation, that will be used to allow the three parties to ask you some questions. Just proceed whenever you're ready.

1540

Mr Stob: First of all, I want to thank everyone here on the committee for the opportunity to present this brief this afternoon and to introduce myself. My name is John Stob, and I've been a partner in the family counselling firm of Lidkea, Stob, Venema and Associates for the past 25 years. We provide counselling to the people of Niagara region—family, marriage and individual—through private practice referrals and through employee assistance programs. I'm here today to present a brief on behalf of the Ontario Association of Social Workers. Has the brief been passed around? Do people have a copy?

The Acting Chair: Yes, thank you.

Mr Stob: OK. Then what I'll do is simply read the brief to the committee.

The Ontario Association of Social Workers is a bilingual membership association incorporated in 1964, with over 3,000 members to date. Practising members are social workers with university degrees in social work at the doctoral, master's and baccalaureate levels.

The OASW is one of 11 provincial and territorial associations of social workers which belong to the Canadian Association of Social Workers, which is in turn a member of the 76-nation International Federation of Social Workers. The OASW has 15 local branches across

Ontario. Our association embodies the social work profession's commitment to a civil and equitable society by engaging in social action related to especially vulnerable and disadvantaged populations, and taking positions on important issues. Today's brief is prepared by the Niagara branch of the Ontario Association of Social Workers.

Bill 8 is titled the Commitment to the Future of Medicare Act. It was introduced in the autumn as the fulfillment of the Liberal Party's promise to enshrine the Canada Health Act in Ontario law, create a health quality council to monitor and provide accountability, and prohibit two-tier health care. As it stands, in our opinion, the bill does not further the implementation of the principles of the CHA, nor does it provide improved democracy, transparency or accountability. Further, it does not prohibit the further erosion of the scope of medicare, the increasing problems of privatization, profit-taking and two-tiering for those services that have been delisted. Further, it gives the Minister of Health sweeping powers without clear intent or democratic control. This brief is an attempt to highlight some local examples from Niagara of how the current medicare system is insufficiently supporting needy persons, and also the need for improved and enhanced services.

As the president of the Niagara branch of the Ontario Association of Social Workers, I am pleased to have the opportunity to address the standing committee on justice and social policy and provide comments regarding Bill 8, the Commitment to the Future of Medicare Act.

We in the OASW are in agreement with the values identified in the preamble of the act. We support the belief in a consumer-centred health system that ensures access based upon need, and not on ability to pay.

In his remarks of February 16, Minister Smitherman emphasized a belief "that the health system is the whole of its complementary parts. It was anchored on the foundation of hospitals and physician services, but to be" daily "relevant, it must evolve to encompass a full continuum of care, including primary health care, home care and pharmacare."

We strongly support a true systems approach to collaboration between consumers, health service providers and government. As social workers, we want to emphasize that access to a continuum of care includes giving people access to the tools that will enable them to make healthy lifestyle choices and changes.

What do we mean by "the tools"? We mean access to health teaching and education, offered by a multidisciplinary team of health professionals. For example, physiotherapists not only treat, but also educate in the best approaches to body mechanics. Occupational therapists enable individuals to optimize their independence and activities of daily living. Dieticians focus on healthy diets and teach people how to adapt to specific needs in their daily living requirements. Social workers provide stress management, coping techniques, problem-solving advice and skills and, often most importantly, advocacy.

Ontario citizens need to have access to these and other professional services, combined with the medical skills of family physicians and nurse practitioners. These services could be delivered in a publicly funded system, publicly governed at a community level, also accessible seven days a week at the community-based level. This is not a new model. Community health centres have existed in Ontario for years. They fit with the principles enshrined within the act. Financially, they provide the best value for the health tax dollar. Administratively, all staff are salaried. This would address the issue of block fees. Yet the act falls short of identifying or strengthening the role for such models. As for accountability, the effectiveness of such service models has been shown in many other previous presentations. Such settings provide a stable, consistent, supportive and empowering environment for all citizens, but are especially effective for those experiencing low income, mental illnesses or chronic, long-standing medical conditions.

Part II of the act replaces the Health Care Accessibility Act and identifies penalties for higher charges or block fees for insured services. The current draft does not seem to address problems of accessibility and affordability for uninsured or delisted services. The onus also appears to be on the consumer to file a complaint regarding unauthorized payment requirements. For many of Ontario's citizens, this would indeed be a very difficult personal step to take.

In keeping with the intent of legislation of universality and access based upon identified need, we suggest that the act, or the accompanying regulations, address a yearly open review of items which have been delisted, done in the context of identified needs for those in especially marginal or low-income brackets.

We are concerned that the language speaks of "pharmacare for catastrophic drug costs." Will this leave the door open for further decreases to current drug benefit programs for the elderly and/or low-income citizens of Ontario? Why does the wording focus on "catastrophic"? Who will define catastrophic versus non-catastrophic drug costs?

A recent locally publicized example might help to shed some light. A week ago, a woman was admitted to a local hospital here in Niagara. Her medical condition had worsened, because she had not taken the medication prescribed for her. She had not filled the prescription. Although she was covered for the cost of the drug, she could not afford the dispensing fee. Thus, she stayed away, and she became yet another person competing for an expensive, high-demand, acute-care bed. This situation was totally preventable if she had known enough to ask the pharmacist to waive the fee, or if the practice of dispensing fees simply did not exist. Perhaps if this woman had been a member of a community health care centre, she might have been supported, spoken to, educated and encouraged to ask the right questions.

In Niagara, homelessness has increased since the reductions in welfare, brought in by the previous government and the lack of building of social housing. This has

a direct impact upon the health care system. The most vulnerable and chronically ill, and those with long-term mental illness, often present at the emergency departments of local hospitals. It is a simple, basic tenet of primary health care: If there is no stable, supportive community, vulnerable people move frequently and more often than the general population and correspondingly suffer more health care problems, thus causing more demand upon an already overloaded hospital system. Currently, it is estimated that Niagara stands in need of 548 more affordable housing units and 66 more case managers to provide ongoing support.

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Part III of the act outlines expectations of accountability and delineates specific circumstances of accountability for health resource providers. We suggest that the expectations be expanded to include accountability for said providers to work together in a consumer-centred approach.

Here in Niagara, there is an excellent example of such co-operation. There is a consortium of mental health service providers funded by MOHLTC dollars. The Canadian Mental Health Association, Gateway Residence, Oak Centre, regional public health and the Niagara Health System have devised a working model to deliver services to mental health clients in need of both moderate and intensive support. CMHA is the lead agency administering the funds, Gateway and Oak Centre provide supportive housing, public health provides nursing support to clients and the Niagara Health System provides community crisis care. Since the beginning of this consortium, 80% of the clients are staying housed, reducing the amount of moving around, and episodes of crises therefore have de-escalated—clearly lowered. These individuals are no longer being seen in the high-cost and high-demand in-patient mental health beds.

However, there is still the issue that many of the clients are unable to either find family physicians or, if they do, are often faced with a cost of \$50 to \$90 to have the medical portion of their application for the Ontario disability support program completed. Again, a primary health care service model would comprise a basic low-cost model of care providing stable, supportive, accessible and effective medicare.

In summary, as the members of this committee review the findings of the consultations and determine specific recommendations, please ask the questions: What real difference will the act and the regulations make to the people of Ontario, both in the present and future? How will the act make a difference to the lady who could not afford the cost of the dispensing fee and therefore ended up in an acute-care bed? How will it make a difference to the woman forced by circumstances to stay in hospital rather than at home for lack of funds to buy a special \$15,000 wound care mattress? Will the legislation specify the accountability to ensure that the funds follow the need?

The important issues are to ensure a true continuum of services, working together, where services are both

accessible and affordable to clients who need them the most. This concludes the presentation we've prepared.

The Acting Chair: We have a minute and a half for each of the parties to ask questions, and I'm going to start with the government.

Mr Brad Duguid (Scarborough Centre): Very quickly, on page 3 of your draft, you talked about accountability and the need to use accountability agreements or an effective accountability system to ensure that providers work together in a consumer-centred approach. I thought the example you used was an excellent example of a success story that we see very infrequently and something that we want to encourage. In his speech yesterday, the minister talked about improving access to family physicians and other members of the primary care team as one of his three key priorities. He's also talked a lot about the need for provision of community-based services. The key to getting there is to have an effective accountability system in place to ensure that we can move all the players along in the same direction. Would you agree with that?

Mr Stob: I would agree 100%. Our belief is that primary health care at the community-based level is clearly the most effective and the most beneficial in a direct way and prevents people climbing up the ladder of the system. Any system that can be put into effect that presses that working together, benefits all in the community.

Mr Duguid: That's good. That's exactly why the government is moving very succinctly toward that kind of model. I think it's important that we have the tools to be able to ensure compliance with the vision we're moving forward with in the health care system. I appreciate that, and I appreciate your bringing this excellent example to our attention, because that's the model I think we really want to move toward for the future.

Mr Stob: We're together on that.

The Acting Chair: Mr Hudak.

Mr Hudak: Thanks for the presentation. You're actually a lot more toned down than most of the presentations we've seen here before the committee today. I was going to say my friend Mr Antal had pointed out a number of serious flaws in this bill. We've seen the government members backpedalling so fast on this they're going to set a record for Ripley's museum just down the street.

Mr Stob: Perhaps if we'd had more than two days to prepare, we might have done the same.

Mr Hudak: You'd get more riled up.

I think the central point of your argument was that accountability is a two-way street. If the government is going to put fines on health care providers for accountability agreements and such, then they have a duty to follow through with some of the funding and make sure that people can afford it. You talked about pharmacare for example, which was referenced in the preamble but was absent from the bill itself.

With respect to the community health model or the process begun with the family health networks, for example, group practices and that sort of thing, would

your vision be to expand that to a variety of health care providers?

Mr Stob: Absolutely. Our vision would be that much more interventive and educational support would occur at the grassroots level, clearly meaning that a whole lot of upward movement into the system, which is increasingly expensive, can therefore be avoided. We support any system that can be put in place which presses that working together within a community between various agencies. We think it is really crucial to (a) meeting needs and (b) watching our tax dollars.

The Acting Chair: Ms Martel.

Ms Martel: Thank you for making your presentation here today. Let me focus on the woman who couldn't get her prescriptions filled because she had to pay a copayment. Some seniors in this province now pay a \$2 copayment based on their income, and others have the privilege and pleasure of paying the dispensing fee, and that again depends on their income.

Here's my concern: If you look in the preamble, it says this bill is going to "continue to support the prohibition of two-tier medicine, extra billing and user fees." At the same time it says that, the government is quite openly musing about the possibility of changing criteria for the Ontario drug benefit plan so that wealthy seniors, rich seniors—however the government is going to decide that—will now have the privilege of paying for their prescription drugs.

I think if the government moves in that direction, you're going to see a whole lot more people in the emergency department seeking care, because they can't afford to pay for their prescription drugs. As far as I'm concerned, there's a direct contradiction between this bill that we're dealing with and the government openly talking about changing the ODB plan, for example.

The second point I'd like to make is, the preamble also says, "recognize that access to primary health care is a cornerstone of an effective health system." My view is that if community health centres were a priority for the government, they would be appearing in this bill. I say that because this government is getting federal money for primary health care. They've got the dollars now from the feds. They don't even have to find it in their own budget; they're getting it from the feds for primary health care.

The former government focused all their money on family health networks, which didn't work. Most doctors did not switch and move into FHNs. I wasn't very thrilled with the FHN proposal anyway, because I didn't think they made the best use of other health care providers in the system who have scopes of practice and a role to play. My concern is that, although we talk about primary health care, although we're getting federal money for primary health care, we see no movement to date on more community health centres etc. If this were a priority, I think the government would be moving on this now, because they actually have the money to make it happen right now.

Mr Stob: I couldn't agree more. Along with it, of course, we would like to encourage that language be put

into the bill so the emphasis is clearly and legally there. I think without that kind of pressure, it's not going to happen by itself, and it needs to be pressed.

The Acting Chair: Thank you for attending. We appreciate your comments.

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HALTON HEALTHCARE SERVICES

The Chair: Our next delegation comes to us from the centre of the universe—Oakville. I'd like to call forward the delegation from the Halton Healthcare Services. Would you come forward, Mr Madon, and introduce the people you have with you today. The rules are you've got 20 minutes. You can use that any way you see fit. At the end of your presentation, we will use the remaining time shared among the three parties. If you would introduce yourself for Hansard, that would be wonderful.

Mr Shavak Madon: Thank you very much, Mr Chairman and members of the committee on justice and social policy. I know I'm going to have a very sympathetic hearing, because the chairman is from my hometown.

The Chair: Anything you want.

Mr Madon: I would like to begin by thanking you for the opportunity of being here today. My name is Shavak Madon. I am the chair of the board of directors of Halton Healthcare Services, representing Oakville-Trafalgar Memorial Hospital and Milton District Hospital. Joining me here today is Barbara Burton, our past chair.

We realize this is the last day of hearings and, as such, I'm sure some of what we are about to say you must have heard already. However, I am also sure it is worth repeating.

We would like to start by acknowledging the process by which you are gathering feedback. When Bill 8 was introduced in November 2003, the government indicated their openness to suggestions and their interest in hearing from stakeholders, a commitment that has been upheld.

We believe this bill is a work in progress. By seeking input, listening carefully and learning from others' experiences, we are confident that the components of this bill will evolve to a point where the government, health care providers and, most importantly, the residents of our communities who rely on our health care will benefit from the fundamental principles of the bill as it is based.

The board of Halton Healthcare Services supports the overarching principles of Bill 8. We support the key provisions of Bill 8, including the establishment of the health quality council, embracing the five key principles of the Canada Health Act, and adding accountability as the sixth principle and thereby strengthening the provisions governing medicare. We support enhanced accountability, including the development of negotiated accountability agreements between the government and hospital boards.

However, like our colleagues across the province, we have some serious concerns that we feel must be addressed prior to the enactment of this bill. We believe

the communities of Milton and Oakville must continue to have a voice when it comes to the health care services they receive and how their local hospitals are managed. We are concerned that this voice may be silenced should the authority for determining service availability and restrictions be removed from the agendas of our board of directors and instead set by a centralized provincial process.

We understand that amendments have been made to the original wording of Bill 8 regarding the accountability agreements. While we have not seen the specific amendments and the wording changes, we are encouraged that the minister has agreed to negotiate the details of the agreements. Agreements that accommodate the need for dual accountability, from the board to the government and the government to the board, are essential and will be received more openly than those which only focus on the accountability of the health care providers.

We cannot stress enough the need for two-way mutual accountability. As our legal counsel has advised, "The bill does not reflect a collaborative or negotiated process, but rather, allows the Ministry of Health and Long-Term Care to unilaterally direct health service providers to enter into vaguely defined accountability agreements and further, to issue broad compliance directives. Accountability agreements must truly be negotiated, not compelled by legislation."

At Halton Healthcare we don't have to look back far in our history to provide you with an example of the impact of provincially set directives being imposed without community consultation. In 1998, the Health Services Restructuring Commission issued a preliminary direction that would negatively impact the pediatric and obstetrical services available at Oakville-Trafalgar Memorial Hospital. In a community that is experiencing unprecedented growth and an influx of young families, our board knew that this type of provincially set direction did not reflect the needs of the community. Fuelled by our commitment to quality community health care services and overwhelmingly supported by the residents of our community, our board was able to change that directive and maintain these services.

Our hospitals were founded by members of our communities, by community leaders, business people and those interested in the health and well-being of their families, their friends, their community. The same commitment that founded our hospitals 50 years ago still exists within the communities, the boards and the associations which guide and support our organization today. These people help us keep our finger on the pulse of the community. They help us fulfill our mission.

Our board of directors must maintain its autonomy. We believe that unilaterally imposed contracts will reduce our governing boards to advisory boards, will undermine community involvement and lead to a gradual erosion of community support and involvement in community health care. Ultimately, this will impact our associated volunteer and fundraising organizations.

Many of our volunteers and our major donors support Halton Healthcare because of their commitment and

belief in community hospitals. We are concerned that this support will be lost if our hospitals are converted into centrally operated entities. We recommend that this bill establish a better balance of accountability with local autonomy and decision-making.

While performance agreements are becoming common in the public sector, there is no best practice or benchmark standard to which we can aspire. However, there are other national examples of performance agreements. We encourage this committee to seek input from those who have first-hand experience with accountability and performance agreements, such as those introduced by the Ministry of Health Services in British Columbia in July 2002. The BC Auditor General's May 2003 review of these performance agreements provides a wealth of information and recommendations that are based on actual experience. One of the lessons we can learn from BC is that the process for establishing performance agreements should not be rushed. Enough time should be allowed for full collaboration between the negotiating parties to ensure local community and governmental needs are met.

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Our board of directors strongly supports the concept of accountability agreements being developed between the minister and the board. The board will then hold its employees accountable, even in extreme circumstances. We do not believe that it is in the best interests of the public to allow the Minister of Health and Long-Term Care to have control over the senior executives of a hospital corporation. Our CEO and chief of staff are accountable to our board, and we hold them to the highest standards. A dual reporting structure involving the minister and the CEO and the board would undermine the checks and balances that we have in place and would not support a collaborative environment.

We know that in the public interest the minister already has the authority, as outlined in section 9 of the Public Hospitals Act, to intervene with the appointment of a supervisor. Bill 8, as we understand it, will provide the Minister of Health with the power to unilaterally change employment agreements with senior hospital executives without the approval of the Legislature or basing the decision on public interest. Our board does not agree with the transfer of power or the ability to command control and impose such dire consequences. The BC experience speaks volumes.

The BC Auditor General noted that performance results should be used initially as a point of inquiry, rather than to impose heavy-handed consequences. The BC report states that, "Traditionally, boards decide on CEO appointments, terminations and remuneration.... we found it was unclear whether the CEOs are accountable to the boards, the minister, or both. This situation creates a number of potential risks. One is that the boards can be bypassed in strategic decision-making, becoming advisory boards rather than governing boards. Another is that the CEO will receive conflicting messages. A third risk is that the CEO will view his or her job as that of managing the board on behalf of the ministry, rather than reporting to the board."

Finally, the auditor's report states that penalties imposed where standards are not met are not effective. Again I quote directly from the report, "Everyone we interviewed spoke about their main motivators being pride and professionalism, traditional values of the public service culture. These were seen as stronger motivators than financial penalties or rewards. Also, many spoke of the most desirable incentive they wanted: the right to make decisions and manage independently."

There is no doubt in our minds, and we are sure you'll agree, that we should all be striving for a more collaborative process based on a relationship of mutual trust and respect so that our work in this area is fair and realistic.

Our last point today concerns the need for clarification of health care acts which will govern our hospitals. The Public Hospitals Act is written to support the patient-physician relationship, which is the primary health relationship. Today, Barbara and I are also representing the voice of 250 physicians working with or through the medical advisory committee. We are concerned that quality of patient care is put into jeopardy if our hospital board focuses time and energy on achieving the standards of performance agreements and ceases to hear the medical service issues.

Furthermore, section 20 of the Public Hospitals Act very clearly states that we must provide service and treatment to those who arrive at our facilities seeking care. I quote the section as it states, "Where a person has been admitted to a hospital by a physician ... and such person requires the level or type of hospital care for which the hospital is approved ... the hospital shall accept such person as a patient."

Contrary to the Public Hospitals Act, Bill 8, as it is presented today, could force hospital boards to reduce and limit services. The question is, which supersedes, the bill or the act? Multiple acts and bills result in overly complex relationships and, in this case, appear to result in contradictory directives. Realistically, our hospital could experience loss of services to our patients and physicians if the board is required to meet a restricted volume requirement of a performance agreement. This would be contrary to the requirement of the Public Hospitals Act to provide treatment. We respectfully ask the committee to review this area of concern and eliminate the ambiguity and contradiction and add clarity to the legislative environment.

In conclusion, we are a strong community organization that is committed to the principles of the Canada Health Act. We have a strong commitment to quality improvement, a commitment that is vital to the success of our health care organization and the industry as a whole. Our board is motivated by the pride and professionalism in the job that we do and the job of our health care providers. We believe in accountability and we are eager to prove ourselves. We will do so not because of the danger of punitive measures and disciplinary actions, but because of our commitment to meet and exceed our communities' expectations. It is our desire to live up to those expectations that will continue to ensure we are

successful in our quest to provide quality health care service. In your consideration of Bill 8, as you review the suggestions and recommendations that have come before you, we urge you to consider actions that will add value and accountability, not complexity and unilateralism, to our health care system. Thank you.

The Chair: Thank you, Mr Madon. You have left time for about one question from each of the parties, starting with the official opposition. Mr Hudak, you have about a minute.

Mr Hudak: Thank you for the presentation—very thorough and well put, particularly with respect to the accountability agreements and the role of the board if this bill were to pass.

You referenced the BC model. I think the deputy minister actually had been part of the BC health care system. Maybe that's where this idea had come from. But they've been caught out, with the actual writing of the bill being at great variance with the way the Minister of Health had described that bill.

I'm sure you've been in contact as well with the equivalent of the Ontario Hospital Association in British Columbia and such.

Mr Madon: I'm sure the Ontario Hospital Association must be in contact. We as a hospital have not been—with the BC auditor.

Mr Hudak: You mentioned what the auditor had found there. I'm just wondering if the hospitals themselves in British Columbia had raised objections to the BC model that the Ontario Liberal government appeared to be putting on Ontario's hospitals.

Mr Madon: I don't think I can speak on behalf of what the community hospitals have done in BC. But I'm sure, based on what the BC Auditor General has said, that changes are bound to come.

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The Chair: Ms Martel.

Ms Martel: Thank you for being here today. Let me just focus on your point at the beginning, "While we have not seen the specific wording changes"—made by the minister—"we are encouraged that the minister has agreed to negotiate the details of the agreements." You would want to take with you today a copy of his February 19 proposal to this committee which sets out the proposed amendment changes; not the actual wording but the proposed direction he wants to take.

I think your legal counsel and yourselves, as a board, would still have two tremendous concerns. Number one, it still makes it very clear that despite the minister saying the agreements will be negotiated, section 22 still allows for the minister, at the end of the day, when the negotiations are over, if they fail, to unilaterally impose a compliance directive or an order, which is a far cry from negotiation.

Secondly, you raised the point about the CEO and who is the master—you know how we used that word—of the CEO. It's very clear that the minister, in section 23, at the end of the day will also still have the ability to apply a compensation clawback or any other financial remedies

from a CEO. So the minister is still trying to assume an employee-employer relationship with your CEO.

I encourage you to take that and show it to your legal counsel, because I don't think your concerns will have been met.

The Chair: Is there anybody from the government side to speak?

Mr Bob Delaney (Mississauga West): Our Chair is from Oakville, so he gets to say the nice things. My job is to see if I can ask you a tough question, but in light of your very helpful brief, I'm afraid that's impossible.

What I'd like to ask you is this: Much of the application of Bill 8 deals with defining effective measurements to set high common standards so as to assist all institutions in knowing how well they're performing. I'd like you to think a little bit about the operations at Halton Healthcare Services. Could you give me just one example of a best practice or a specific area that you're familiar with that you think you could showcase in such a system of effectiveness measurement to demonstrate how effectively you use people, time and money?

Mr Madon: One example I can obviously give you is our emergency department. I'm so proud of it. Many times, quite a few hospitals would say, "We cannot take any new patients," whereas in our case, if anybody comes to our door, we are never going to turn that person away, even if we have to bring a stretcher, put the stretcher in the corridor and look after that individual. That's how we manage our government dollars, which is so important. We look after everyone possible.

The Chair: Thank you for coming today. It's a long drive, but it's a nice day. We appreciate your input.

HALDIMAND WAR MEMORIAL HOSPITAL

The Chair: Our final delegation today, and of our entire hearings at this point, is from the Haldimand War Memorial Hospital. Mr Walker McQuatty is the chair of the strategic planning committee. You have 20 minutes to make your presentation as you see fit. Any time that is left over will be split among the three parties. I'll let you get settled before I start the clock.

Mr Walker McQuatty: I'm a member of the board of trustees of the Haldimand War Memorial Hospital. I'm a past chair of the board. I've been on the board 14 years now and will probably be on it for about another year. Thank you for letting us have this opportunity to have input. At the end of the day, I'm sure you've heard most of what I have to say already: There is a report that I've circulated. I don't know that I'll get through everything in the report within the time. I'll just mention that this report is sort of a joint effort by members of our board. Our board is very interested in what's happening with Bill 8 and has wanted to have input.

If I can briefly give you a little bit of background about our hospital, we're in Dunnville. It's a small town in southern Ontario. The hospital itself has been in existence since the 1930s. We give 27 different primary health care services. We also have shared services with

other hospitals. We have various clinics and we provide many programs in the community. Our hospital has been very innovative. We have a pilot postpartum outreach program in the town, we have a health promotion program within the town, and other hospitals have come to look at what we've done.

In Haldimand county there are two rural hospitals. I think earlier today you had a presentation from West Haldimand General Hospital, and we're basically networked with West Haldimand.

In our county we have a rapidly aging population. There are some figures in the report. We're expecting an increase of about 45% in those over 65 years of age, and in the zero-to-19 age group, we're expecting a decline of about 80%. So there's a huge shift in the population of our county.

Mr Hudak is quite familiar with our hospital and has been very helpful to us. At the moment we're into a very major initiative: We are adding a 64-bed long-term-care facility at the hospital facilities, adjacent to the hospital. We're working on the development of a primary health care centre in conjunction with the hospital. We are also working on developing an assisted living complex for senior citizens in conjunction with the hospital, and sharing services. We're doing those things with a view to the aging population we're dealing with, and we've tried to be very proactive in the community.

We have an active hospital auxiliary—22,500 volunteer hours in the last five years—that has raised over \$137,000 for the hospital in the last five years. We also have a very active health care foundation in the community. It's not a hospital foundation but it raises money for all the health-care-related items in the community. It has so far donated over \$4 million to our hospital, which we think is quite a lot for a small community.

As Mr Hudak and maybe some others will know, hospitals have participated in a report card in the last few years. We have, on several occasions, been one of the top five hospitals in the province in the report cards.

Our board is made up of local people, community people, professionals, school teachers, housewives—just people with a variety of backgrounds, all civic-minded people. We feel that we have been dealing with accountability already through various areas of government: district health councils, the provincial government, the federal government. One of our questions is, how much more accountability could we have than what we already have with the community itself? We consult with our community and try to make decisions that reflect our community.

We feel it's clear that our hospital, like other hospitals, has been a leader in being efficient, accountable and proving value for money. I'm told that in Ontario we have the lowest number of acute care beds of any province, our per capita hospital expenditures are the lowest of the provinces, our in-patient utilization is the lowest of the provinces, the length of stay is the most efficient, and use of day surgery is most efficient.

I understand there has been correspondence between the OHA and the minister and there are some potential

changes to the draft legislation. The minister is going to review comments and make some suggestions. We would urge that once the proposed changes are documented, we're allowed further consultation. We're very interested to see what the actual wording of the changes is.

We strongly believe that for this legislation to be successful, Bill 8 should have the support from local governance, like our hospital, for it to work. We feel that the local volunteer boards are the ears, the eyes and the hearts of the community and are totally accountable within our community for providing adequate health service.

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Having said that, we have some specific comments about Bill 8. In the preamble, we feel that the public accountability should be both the government and the health resource providers. It should be clear that the government is equally accountable.

With regard to part I of the act, which is the Ontario Health Quality Council, we strongly suggest that the council have the power to make recommendations to the Legislature. That would enhance the accountability to the public so that the report would be reviewed at the Legislature.

With regard to part II of the act, which is about accessibility, we're concerned that there's a potential to prohibit payments to some of the doctors who work at hospitals. I think some are called hospitalists; they are laboratory physicians; there are other types of doctors who work in hospitals who may be paid directly. We're concerned that the wording may prevent that and that could, in effect, reduce the access to health care.

We also note that Bill 8 doesn't require the province to fund health care at any particularly adequate level. The Canada Health Act has requirements for the provinces to fund health care and our suggestion is that the act should also make it clear that the province is responsible to provide adequate funding for health care.

We have comments on part III, the accountability section. The first is that our hospital has already been performing survey report cards since 1998 and we've also been, as I mentioned, accountable to district health councils and the government and to our community that we consult with. So we feel we already have a level of accountability.

Our CEO and other members of the staff have participated in developing a hospital funding formula. We're supportive of effective and workable multi-year funding and the development of an appropriate performance agreement.

We feel very strongly that in the draft legislation the compliance directives should be deleted. It seems like an extreme, unfettered power that we feel is unwarranted.

In section 19 of the draft legislation, we believe that what should be deleted is the reference to "executive function or position" and "primary and executive functions or positions." Rather than that, we propose that the wording that would be put in is "health service provider" means any corporation, agency or entity that provides,

directly or indirectly, in whole or in part, provincially funded health resources."

We'd also like to point out that there's no provision set out in the draft legislation that the minister acts in the public interest when implementing performance agreements. We suggest that should be set out clearly, that in the administration of section 20 the minister is governed by the public interest.

With regard to subsection 21(1), we would suggest an amendment. It's basically, and I know you've heard this before, that the accountability agreements must be negotiated, but the amendment would be, "Subject to subsection 21(2), a health resource provider and the minister shall, if requested by the Lieutenant Governor in Council, enter into a negotiated accountability agreement with any one or more health service providers."

We certainly feel very strongly that Bill 8, as it is drafted, undermines the local voluntary governance in our public hospitals. There are two main ways that it does that. First, by directing hospital boards to sign an accountability agreement without negotiations, the government is basically removing the checks and balances in our local community. Secondly, by having the power to make or effect an amendment that affects an employee of the hospital, the government is again usurping the role of the board.

We're concerned that as a result of the wording of Bill 8, our community will lose a say in the service they receive and how the hospitals are managed.

We're worried that sections 21 and 22 negate community input by directing the hospital to sign an agreement that hasn't been negotiated or agreed to but is basically imposed unilaterally. The position of our board is that those agreements must be negotiated.

I'm told that the British Columbia auditor has already rejected the idea of ordering changes to employment agreements, and that this is because they are detrimental to the governance of the association and are ineffective in improving performance.

While it might be unclear under the draft legislation—this may be the same issue I heard someone speaking about just a few minutes ago, but it may be difficult for us to understand whether our CEOs are accountable to our board or whether they are accountable to the ministry, or both. We're concerned that once the board is bypassed in their strategic decision-making, they lose their ability to function as a governing board.

We'd like to point out that under the Public Hospitals Act, the minister already has authority to appoint a supervisor, an inspector or an investigator. This is only done when there are serious financial or operational problems, but that power is already there.

In section 21 of the act, we suggest an amendment to say, "An accountability agreement between the health resource provider and the minister may require that the health service provider enter into an agreement with the chief executive officer concerning his or her performance, in that capacity, on terms to be negotiated between

the health service provider and the chief executive officer."

As Bill 8 exists, we feel the question is, who will ultimately direct the CEO? Is it the hospital board or is it going to be the minister? We're concerned and suggest that this is most relevant to a volunteer board of governors. It's going to have a negative effect on the good relationship that we've had in the hospital for many years.

The proposed powers of the minister to materially change a person's terms of employment we call draconian. It's unsatisfactory; it's unacceptable. We want the best people to be running our hospitals. I have to question whether we're going to find the best people who want to take on those jobs when their employment terms can be changed, when there are all these issues about severance clauses and different conduct. People take jobs that are very important and they want some security. They leave other jobs to take them. When we can change their contract on them, they're going to be less likely to want to take those positions on.

Our hospital, I'm glad to say, has thus far always operated in a surplus position despite other funding shortfalls. We recently did a review, and in the last 10 years our base funding has actually gone down by over a per cent and our expenses have increased, but we have managed to keep ourselves in a positive situation.

We have serious concerns about the future of public interest in our community and how it affects the board. What we're worried about is becoming a puppet board. If we can't fulfill our obligations and responsibilities because they're controlled elsewhere, yet we're trying to be held accountable by the community, how can we be? We strongly suggest that any accountability agreement be negotiated, not imposed, and negotiated freely and openly between the parties.

We're also concerned that our relationship with the community is going to be compromised. If the accountability agreement diminishes our authority as a board, I can certainly tell you that would not be well received in our community and it would seriously affect our ability to obtain volunteers and the capital that we have been able to attract over the years. It's likely we would lose out on some of that if we didn't have control lately. As far as the volunteer boards, in my mind, you don't fix what isn't broken. The volunteer boards are working quite well with the communities, finding out what works for the community in terms of health care services and what the needs are. We would like to keep that input local.

I managed to keep within my time, I guess. Are there any questions?

1640

The Chair: You did very well. We have time for probably one question from each party, starting with Ms Martel. You only have about a minute, unfortunately.

Ms Martel: Thank you for being here today. Your page 11 refers to section 27 and the minister's clarification that this applies only to CEOs, which of course is

true. But what is also clear is that the minister still retains the authority to apply a compensation clawback to a CEO or to apply other financial remedies. So I take it that your concern as a board about your role as an employer has not been resolved.

Mr McQuatty: Absolutely not. And it's not just an issue for hospitals; we've seen it in other areas. As I say, our CEO has been 37 years, I think, at our hospital. When he leaves and we bring in someone else, we may have to bring them in from somewhere and we may have to make agreements with them so they know they are secure. If they know that they can be turfed on certain terms very easily, they may not be as interested in coming.

The Chair: Ms Smith.

Ms Smith: Thank you very much for coming. I was unclear through your presentation whether or not you had seen the framework for potential changes to the legislation that the minister presented to this committee last week.

Mr McQuatty: We have, yes.

Ms Smith: Then I just have one question for you. On page 8 you say, "With respect to subsection 21(1), accountability agreements, we suggest that subsection 21(1) should read as follows: 'Subject to subsection 21(2), a health resource provider and the minister shall, if requested by the Lieutenant Governor in Council ... do either or both of the following,'" and then you've got "1," and I expect that 2 is paragraph 2 in the act. I'm just wondering by that suggested amendment, are you of the position that hospitals should not be entering into accountability agreements with the Ministry of Health?

Mr McQuatty: No, but the accountability agreements have to be freely negotiated.

Ms Smith: And if they are negotiated, you're fine? I mean, here you're basically saying that you would only enter into accountability agreements if they were directed by cabinet.

Mr McQuatty: Right. I don't think it's our position that we wouldn't otherwise enter into an accountability agreement, but again, it would have to be freely, willingly negotiated.

The Chair: Mr Hudak, last question of the day—the week.

Mr Hudak: All that pressure, Chair.

Interjection: Make it a good one.

Mr Hudak: I'll do one of my standards.

Mr McQuatty, thanks very much for being here, and congratulations as well on the great work at War Memorial. I'm the proud representative for the Dunnville area and, as was mentioned, it's consistently one of the top-performing hospitals in the province. So I'm very pleased that you are here today for the presentation.

A bit earlier on, somebody said that this bill is a bit of a work in progress. Well, I can tell you it's the farthest thing from a masterpiece this committee has ever seen. It makes van Gogh look clear. This bill will resemble in no way at the end of the day what it was at first reading. In

fact, many of us feel the bill should be scrapped entirely and we should start right from the beginning.

You're absolutely right: You have had a chance to look at the minister's promises in the areas for amendments, but as my colleague Ms Martel pointed out, it still falls short in the concerns you have about the Ministry of Health putting the strings on the local CEO and therefore undermining the board and the volunteer governance that has been a tradition in this province. What would your suggestion be for an amendment to this particular section with respect to accountability agreements and the relationship between the Ministry of Health directly to the CEO?

Mr McQuatty: You mean in terms of changing the provisions of the CEO?

Mr Hudak: Particularly on the relationship between the CEO and the Ministry of Health, the direct reporting relationship that we believe even the proposed amendments don't clear up.

Mr McQuatty: My personal opinion is that it should be between the hospital and the CEO, that the agreements be between the minister and the hospital and then the hospital and the CEO, and the hospital deal directly with the CEO. That's my personal opinion.

The Chair: Thank you for coming today. We certainly appreciate it. We did enjoy your input.

ELIZABETH BALANYK

Ms Elizabeth Balanyk: May I make a comment from the public?

The Chair: It's kind of out of order. How long is this comment?

Ms Balanyk: It'll take two minutes.

The Chair: OK. Would you come forward so we can hear you? I'm not sure if this is entirely within the rules but you look like you're a sincere person.

Ms Balanyk: I'm a very sincere person. Kim knows me well. He's a great guy and he's been trying to help me.

The Chair: There you are. You're in.

Ms Balanyk: He's been very helpful.
Interjection.

The Chair: That's right: I've never seen this woman before in my life.

You have a couple of minutes.

Ms Balanyk: Thank you. I'm a registered nurse in the city of Niagara Falls and have been so for 35 years.

The Chair: Can we have your name, please?

Ms Balanyk: My name is Elizabeth Balanyk. I'm really here today to bring a very important issue that's been brought to my attention, and Kim knows about this. It's been brought to my attention that at the Ontario Works offices and social services offices in Niagara Falls and in Ontario they demand a citizen's health card number in order for identification of that person to be approved for any acceptance to any type of assistance they ever offer, which they often quote at \$245 a month. Of course, it's not any higher than \$520 a month.

I'm here to ask a couple of questions, and I've asked Kim and he's been looking into this, but it really is becoming a great issue. Where did this rule come from that we have to give our health card number to Ontario Works employees, who are not doctors, who are not hospitals, who are not labs, who are not X-rays? I think it's a very dangerous thing to do. So I need to know where it came from and if it's an absolute rule. If in fact it is an absolute rule, it needs to be changed.

As a nurse, and dating a doctor for 10 years, I will tell you health card numbers in the wrong hands are very dangerous. You can lose patient confidentiality. They can take that number and they can charge whatever they want. You get the wrong person and they can start charging—they can send it out to OHIP and make all kinds of money, if they want to. Lucy Magda was in St Catharines, and that's my point, really. So things in the wrong hands are very dangerous.

I've heard a lot of rhetoric here today. I've been fighting a legal battle myself. I've been fighting the Ontario Nurses' Association for 18 years and I've been fighting the Greater Niagara General Hospital. I'm now fighting the region of Niagara, and it all started over a romance. I'm writing a book called Flaws in the Laws. You really will want to read it.

The reason I'm saying all this is because at the end of the day—I've worked in long-term care, I've worked at Upper Canada Lodge and I can tell you the letters that I've received that broke my heart, they were so wonderful.

But to bring something to your attention, at the end of the day it's the patient we really have to worry about. We're all human beings here. We're all getting older. We're all going to end up in one of these homes one day. Believe me, trust me. You're very aware of a lot of the serious problems. However, you may not be very aware of the management—or lack of it—problems. Because of the lack of management, who are there to guide their staff, that is where you get a lot of your problems. So it may be something you should look into, because if you don't, this is what happens, folks. You get judges slamming facts and it costs you money. You get nurses suing

over SARS; Doug Elliott suing the three levels of government—federal, provincial, city of Toronto—for \$600 million. It costs you money. It costs us money.

The Chair: Ms Balanyk, thank you very much. I've extended you more latitude than I thought I was going to. There probably is an answer to your question.

Ms Balanyk: I need the answer about the health card number.

The Chair: Unfortunately, it won't come from this committee, as much as I wish I knew the answer. I will undertake or Kim or somebody will undertake—your MPP will undertake, I'm sure—to find out who can give you that answer, because there must be an answer out there.

Ms Balanyk: If it does exist, please change it, because if you don't change it, you're going to run into a lot of problems. I'm not cattle. I think about what people ask me. Another one is your SIN number too. Why do they need it? It's only for an employer who employs you. They don't employ me.

The Chair: Thank you very much for coming. We appreciate it.

Ms Balanyk: Good luck.

The Chair: Thank you.

Interjection.

The Chair: That's our job.

We're going to adjourn until March 9 in Toronto. I just wanted to extend my thanks to staff. It's the first time for many of us. I think staff did a wonderful job, considering probably half of us are rookies. Certainly I'm a rookie Chair. Special thanks to the parliamentary assistant and the opposition critics from both parties. I think you did a wonderful job. Thank you for your very thoughtful consideration. The respect that you showed the public was great during the last two weeks. The civility we displayed to each other I think was wonderful. There were times when there were a few little sparks, but I don't think it was too bad. So my thanks to you all and let's move on. We're adjourning until March 9 in Toronto.

The committee adjourned at 1652.

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First Session, 38th Parliament

Official Report of Debates (Hansard)

Tuesday 9 March 2004

Standing committee on
justice and social policy

Commitment to the Future
of Medicare Act, 2003

Assemblée législative de l'Ontario

Première session, 38^e législature

Journal des débats (Hansard)

Mardi 9 mars 2004

Comité permanent de la
justice et des affaires sociales

Loi de 2003 sur l'engagement
d'assurer l'avenir
de l'assurance-santé

Chair: Kevin Daniel Flynn
Clerk: Susan Sourial

Président : Kevin Daniel Flynn
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LEGISLATIVE ASSEMBLY OF ONTARIO

**STANDING COMMITTEE ON
JUSTICE AND SOCIAL POLICY**

Tuesday 9 March 2004

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

**COMITÉ PERMANENT DE LA JUSTICE
ET DES AFFAIRES SOCIALES**

Mardi 9 mars 2004

The committee met at 1003 in room 151.

**COMMITMENT TO THE FUTURE
OF MEDICARE ACT, 2003**

**LOI DE 2003 SUR L'ENGAGEMENT
D'ASSURER L'AVENIR
DE L'ASSURANCE-SANTÉ**

Consideration of Bill 8, An Act to establish the Ontario Health Quality Council, to enact new legislation concerning health service accessibility and repeal the Health Care Accessibility Act, to provide for accountability in the health service sector, and to amend the Health Insurance Act / Projet de loi 8, Loi créant le Conseil ontarien de la qualité des services de santé, édictant une nouvelle loi relative à l'accessibilité aux services de santé et abrogeant la Loi sur l'accessibilité aux services de santé, prévoyant l'imputabilité du secteur des services de santé et modifiant la Loi sur l'assurance-santé.

The Chair (Mr Kevin Daniel Flynn): It's a few minutes after 10 o'clock. Could we come to order? Welcome back, all.

We're here to consider Bill 8. We have some late amendments from the opposition, and the government is withdrawing one amendment and replacing that with another. I'd like at this point to deal with that and ask if there is unanimous consent to accept the amendments. OK. Thank you.

Just so we're all on the same page and the same package, the package we are working from for the amendments is the one that is numbered at the top. If you go to the top right-hand corner, you'll see page 30, page 20 or whatever it is. That's the package that we're working from. The clerk is distributing the amendment from the government replacing the one amendment with this. The clerk has also put the amendments in the sequence in which I anticipate the committee will be disposed to deal with them.

We are going to start with five-minute statements from each of the three parties. We'll start with the government.

Ms Monique Smith (Nipissing): We're delighted to be here today to do the clause-by-clause review on Bill 8. I will not take too much of our time today with an opening statement, as we have a lot of work ahead of us. I would just state that we were happy to take this bill out after first reading, recognizing that it needed some work.

We said from the very beginning—the minister was here on the very first day and noted that we would be bringing extensive amendments, and we are doing that today.

We have had extensive consultation with stakeholders across the province. The amendments that the government will be presenting today reflect the changes that were suggested by many of the stakeholders and address a number of the concerns that have been raised. We are pleased to go through this clause-by-clause exercise, and we believe the legislation as it will stand at the end of this review will be stronger and will reflect the themes that we hold dear in trying to protect medicare in Ontario.

Mrs Elizabeth Witmer (Kitchener-Waterloo): We've certainly appreciated the opportunity to participate in the analysis of this bill. I want to thank all of the deputants who appeared before the committee. I think we received some excellent information and certainly some great recommendations.

Leading up to today, we haven't had a lot of time to consider the government's amendments, but at first blush, although there certainly has been discussion and conversation and recommendations, I do believe that the bill still does fall short when it comes to section 3, the accountability section. I still have some very serious concerns, as I know our stakeholders do, about the drafting of the provisions related to accountability, and the fact that, at the end of the day, hospitals will still be forced to sign performance agreements.

I would hope that the government, after we finish clause-by-clause, would be amenable to sending this bill back to the stakeholders for further consultation of these changes, because I don't believe that the bill goes far enough in responding to the concerns when it comes to the accountability agreements. I know there are reservations for hospitals, whether CEOs or boards. I know that certainly the unions, the employees, are still really very fearful as to the power that the minister or the ministry would have in regard to these accountability agreements.

My recommendation would be that if we really want to make sure that we are reflecting the input, if we want to make sure that people have sufficient time to consider these responses from the government, we would allow for further public consultation on this bill, particularly as it pertains to section 3, the accountability section.

Ms Shelley Martel (Nickel Belt): Let me make some comments about the process itself and some comments about the bill.

First, about the process, there is no doubt that this was to be a signature piece for the government. It was a bill that was to set a different tone, a bill that would set a different direction, that would set the new government apart from the old in terms of its dealing with its stakeholders and the public, moving from what has been a very confrontational past eight years to one of co-operation in moving forward. I think it was no accident that the bill was introduced on the first anniversary of the release of the Romanow report, to try, in public relations terms, to give a sense to the people that the government was really serious about protecting and enhancing and moving forward on medicare.

It was also not an accident in that context of a public relations exercise that there was quite a big to-do at Hart House the morning of the day the bill was introduced. The Premier was there, the Minister of Health and Long-Term Care was there and Commissioner Romanow was there. Everybody had great things to say about medicare and how this bill was going to support it.

The party ended when the bill was introduced. The very same weekend that the bill was introduced, the Ontario Medical Association was on the phone to the minister's office to say, "What are you doing? Look at the tone of this? Penalties—we're going to be in jail for a year for administrative mistakes that we've made. Look at the penalties." The OHA was soon on the phone after that to talk about section 3 and the overwhelming and incredible powers that were proposed for the minister. So what became a signature piece for the government rapidly fell apart.

That has certainly been confirmed during the course of the public hearings. Far from a signature piece, I think regrettably for the government, it has been anything but. The tone continued, the kind of confrontational approach that we've had to endure under the Tories. That's not where the government wanted to be, but is surely where they ended up.

The process is such that the bill is so flawed that we should have had a new bill. It is not time-allocated, although I appreciate that the minister needs this bill now in order to deal with his hospital funding announcement. We heard so much concern—frankly we heard the concern from the minister on day one that this bill would have to be amended—that we should not be here today. The government, after hearing from people, should have gone back, rewritten the bill and, frankly, introduced a new bill when we sit again. That would have been a much better process.

1010

I say that because there has been a mad rush to fix this bill. There were consultations going on extensively between the minister and the OHA on Thursday morning. There were conversations between the College of Physicians and Surgeons and the ministry on Friday afternoon. There were people who worked over the weekend to put the amendments together. We received a package late last night and even another change this morning. That's a bad way to do business. It reminds me of some

tax reform changes that the previous government made in a mad rush, and for the next seven sessions that we sat—the sessions referring to March to June—and then in the fall, the government had to bring forward legislation to fix the original bill. Seven times we had to deal with fixing the original bill because it was done in a mad rush and not done properly.

I say to the government, I think you would have been much better served after having heard from people, instead of engaging in the mad rush to be here today, to actually have gone back and reintroduced a new bill, because I think we are going to be here again and again, fixing some of the sections that you have tried to fix, even up to and over the course of yesterday.

Because the bill has been so flawed and because I worry about the process from here on in, which I think will be a process where we will have to be fixing things that have been missed, we made a decision not to put forward amendments. We think the government would have been much better served, the process would have been much better served, if the government had taken its time after having heard everything—and there was a great deal to hear and most of it was negative. The government would have been much better served to actually bring in a new bill for us to consider when the House starts again, because we are going to have to go to second reading, we are going to be back in clause-by-clause—I'm quite certain of it—and we are going to have public hearings again. We could have done all that with a new bill, instead of the rush that we're trying to deal with today.

With respect to the bill itself, the government members have heard before and they're going to hear again, probably a few more times before this bill is over, that there is, in my opinion and the opinion of New Democrats, a huge disconnect, a great divide between what the minister says the bill will do to support and enhance and promote medicare and what the contents of the bill actually put in place. Frankly, the contents of the bill do not, in my opinion, either support or enhance medicare in the way I think we, as New Democrats, should. Let me give you some examples.

In the preamble, which of course everybody can support and I've said this before as well, it says "our system of publicly funded health services"—that's what we want to protect. At the same time, we have a government that is moving forward to privately fund hospitals in the province of Ontario. That doesn't make any sense economically, because it's much more expensive for us to privately fund hospitals in this province than it would be to publicly fund them, which is the traditional way. Frankly, once you open the door to privately fund hospitals, then you open the door to allow private companies to privately manage the system as well.

I look at the example of the private MRI/CT scan clinics, which the government said they were going to shut down. They have not been shut down. Competitive bidding in home care, we heard from presenters before this committee, is doing great damage—nothing in the

bill to shut that down. The bill talks about ending user fees. At the same time, the finance minister is musing openly about ending universality of the drug plan.

So we have a huge disconnect, a huge divide between what the bill purports to do and what the contents actually do. For that reason, I have not been supportive. And unless and until there is a change—and I doubt there will be—we will not be supportive.

The Chair: Let's proceed then. Are there any comments, questions or amendments, and if so, to which sections? It's a question I'm compelled to ask, but I think we know the answer to that.

Mr Frank Klees (Oak Ridges): If I might just make one comment. As you know, I participated in these hearings over the last few weeks, and you've heard—and the record will show—that I, on a number of occasions, indicated that, because of how badly flawed this bill is, it would be my personal view as well that it would no doubt have been in everyone's interest if this bill was scrapped and we started over again. Most of us, I think, agree with the principles that were set out in the preamble. I can tell you, having had an opportunity to review the amendments, while we ourselves did what we could—we are putting forward amendments today that will soften the blow somewhat, nevertheless, I'd like the record to show that my personal view is that it would be in the public interest if this bill were scrapped, that we started over again doing the right thing; that is, draft a piece of legislation that would be consistent with the principles set out in the preamble. I don't believe that, even with the amendments we'll get there. I want the record to reflect that.

The minister started out in this hearing room presenting a bill that, it was obvious to us, he either hadn't read or didn't understand at the time. Halfway through his presentation, he made it clear that the tone of the bill was not what it should be. In successive comments he made following that, he also made it clear that he would do what he could to fix this bill. He went from making apologies to being embarrassed about the state of the bill. Now we see that he has fallen prostrate to the stakeholders, to the point where we have probably 10 pounds of amendments here that will take us some time to get through. It was a valiant effort on his part, but he didn't do the right thing. He should have done the right thing, and will have to bear with the government as they force these amendments and this bill through, which I would say is inconsistent with the commitment the Premier made on the election campaign that he would do the business of government differently. We're very disappointed in that.

The Chair: Thank you, Mr Klees.

If everyone will turn to their package, the first motion that I have placed before me is a PC motion. It would be a new section 0.1.

Mrs Witmer: I move that the bill be amended by adding the following section:

"Public interest"

"0.1 In acting under this act, the minister must act in the public interest."

There was a tremendous amount of concern surrounding this bill, and certainly much of it focused on the fact that there was no reference made whatsoever for the minister to ever have to act in the public interest. So the inclusion of this type of wording would specifically require the minister, as the designate of the Premier in health care matters, to obviously always and only act in the public interest.

This is absolutely necessary to preserve public accountability, so we believe that this amendment needs to be made. Otherwise, it's going to undermine public confidence in the health care system, which this bill has done to a large degree anyway, based on the manner in which it has been introduced. We also know that under the Public Hospitals Act the minister is bound to act in the public interest, so we found it a grave and serious omission that in this piece of legislation there would be no reference to acting in the public interest. This may be an indication of the sloppy manner in which the bill was originally drafted.

The Chair: Any further debate on the amendment?

Ms Martel: Chair, I'm looking at the Draft Framework—Potential Changes that the minister gave to the committee via the parliamentary assistant a couple of weeks ago. In the preamble it says, "Include reference to ... 'public interest' in the preamble." Is that coming later, or is it not coming at all in this section?

Ms Smith: I'd like to address both concerns raised by Ms Witmer and Ms Martel. "Public interest" will be incorporated into subsection 20(2), as well as in the preamble in the government amendments that we are proposing. In fact, it goes further than the amendment that you're proposing here, Ms Witmer.

1020

Mrs Witmer: Would you give us the page? That's part of the problem. Because this bill was so poorly drafted originally, and we didn't get these amendments in time to cross-reference, could you tell us where it is so that we could make a decision?

Ms Smith: On page 39 of the package that you have before you this morning, you'll see subsection 20(2), and on page 80 of the package you have before you, you'll see an amendment to preamble paragraph 7.

Ms Martel: Can I ask why the changes to the preamble are coming at the end? Because we're going to pass the preamble and then we're going to get to it later on.

The Chair: I believe we deal with the preamble at the end of our proceedings. I'll check with the clerk.

Interjection.

The Chair: Just trying to abide by the rules.

Any further debate on the amendment?

Those in favour? Those opposed? That amendment is lost.

We move on to page 2. This is a government motion.

Ms Smith: I move that section 1 of the bill be amended by adding the following definition:

"health system organization" means,

“(a) any corporation, agency or entity that represents the interests of persons who are part of the health sector and whose main purpose is advocacy for the interest of those persons,

“(b) the college of a health profession or group of health professions as defined under the Regulated Health Professions Act, 1991, or

“(c) a health resource provider within the meaning of part III, (“organisme de santé”).

The Chair: Speaking to the motion?

Ms Martel: Could I just ask, for the purpose of the rest of the day, if the parliamentary assistant is going to speak to the changes or if staff are? Some of them might be clear. I understand that clearly this is a definition, but I'd be interested in knowing, is it affecting some other parts inside, either to clarify that people are included or excluded from the provisions of the bill?

Ms Smith: We do have staff available. If there are any specific questions, I'm happy to call them up. If there's a specific question on this section, I'm happy to address it.

Ms Martel: Can I ask, then, the purpose of a new definition? I don't remember this coming forward as a recommendation from any particular group. Is it designed to fix something else that's coming?

The Chair: Ms Smith, would you like to answer that, or would you like to call somebody forward?

Ms Smith: I think I can address it, although if you need more detail, Ms Martel, I'm happy to get you more detail. What this does is address the concerns surrounding membership on the health quality council and the fact that we were going to limit membership and preclude those who represent stakeholder groups specifically from being on the council.

Ms Martel: So there will be a change later on as well in the section where it looked like hospital boards were going to be excluded, or members of hospital boards?

Ms Smith: This particular amendment actually continues to exclude members of hospital boards and CEOs of hospitals. It also excludes stakeholder groups and members of colleges. If a present board member wishes to sit on the council, they can resign from a hospital board and be a member of the council, but the dual role will not be allowed under this amendment.

Ms Martel: Can I just ask the reason for that? Let me make this comment. The people who sit on hospital boards do that voluntarily. It's not a paid position. So I'd have much more difficulty seeing a conflict of interest, even in its broadest sense, in that regard than I would, obviously, for someone who has a paid position, for example at the OHA, which is very clearly an association set up to lobby. I think there is a distinction, and I'm wondering why the government isn't making that distinction.

The Chair: That could be the essence of the debate. Ms Smith, did you have an answer to that, or did you want to go to staff?

Ms Smith: I believe the reason we would be requesting that someone who presently sits on a board not sit on that board is that they come representing a broader

perspective and that they not feel they are there representing their particular hospital interest. The people we want on the council are people who reflect a broader interest, and we do want to include the patient population and the hospitals, but we don't want them absolutely representing one particular institution. So we would ask that they resign their voluntary position on a board to sit on the council. We think they'll be able to make a contribution that way and not feel fettered by their responsibilities to their particular board.

Ms Martel: If I might, I guess I disagree with where the government is going. I feel the sense that if you are a—I don't want to use the words “paid lobbyist,” because I'm not trying to undermine anyone, but in some ways, if you are representing an association in a paid position, that's what you do. We're talking about volunteer people who have a lot of expertise and who are going to then have to make a decision: Do they not continue in the work and the contribution they can make on a hospital board on behalf of their community in order to do this other work on behalf of the government?

I'm not trying to denigrate that job, but I'm just not sure why we're asking people to do that and why they can't play a dual role. If I thought there was some kind of conflict in terms of money, I would make a vociferous argument to have them off, but I just think the government is going a bit far down the road in terms of who can participate and who can't. I think it's not going to serve people well if you go to the extreme that someone who is a volunteer and has a long association of working for the community and has a contribution to make on a hospital board has to forgo that in order to participate on the council.

Mrs Witmer: I would certainly concur with the comments that have been made by Ms Martel. I think it would be grossly unfair to the volunteer, who oftentimes has better knowledge, first-hand knowledge, of the health system than many, many other people in paid positions, who sometimes are there lobbying on behalf of their organization. I think to deny them the opportunity to participate here is very unfair.

Mr Klees: I'd like to ask the parliamentary assistant, specifically in this amendment, which part of it excludes members of a hospital board?

Ms Smith: I'm sorry. Which part of this amendment excludes a member of a hospital board?

Mr Klees: Yes.

Ms Smith: Clause (c), “a health resource provider within the meaning of part III.” It must be read in conjunction with the amendment proposed on page 5. The amendment on page 5 refers to subsection 2(7) of the bill.

Mr Klees: Sorry. You're going to have to help me with this.

The Chair: Can anyone elaborate on that a little bit? Ms Smith?

Ms Smith: Certainly. Subsection 2(7) of the original legislation reads, “A person who is a member of the board or a senior staff member of a health system organization may not be a member of the council.” We

will be amending that to include “or the chief executive officer or an officer.”

Mr Klees: Thank you very much. Chair, I want to as well register my concern about this. If there is anyone at all in our communities who understands the health care system, and particularly the functions of a hospital, surely it’s someone who sits on the board of a hospital. These are not professionals in the health care system, as a rule. I don’t have a problem if you want to exclude health care providers directly who sit on boards, but surely there could have been an exception made for volunteers who sit on these hospital boards, who often bring very broad business experience, who often bring a broader community perspective, and who, I would suggest to you, as members on the board, see their role as advocating for the public interest, certainly not advocating for a particular health care professional discipline on that board. I believe the government is excluding individuals who could serve the public interest very well, and I want to register my strong objection to this.

The Chair: Are there any further speakers?

Seeing none, those in favour of the motion? Those opposed to the motion? That motion is carried.

Shall section 1, as amended, carry? All in favour? Those opposed? That motion is also carried.

We move to page 3: Ms Witmer.

1030

Mrs Witmer: I move that the bill be amended by adding the following section:

“Adequate funding

“1.1. The government of Ontario is obligated to provide adequate funding for the health system.”

This bill, when it was introduced, purported to do away with two-tier health and queue-jumping, and made all sorts of other claims. The reality is that when we talk about queue-jumping and two-tier health, those aren’t the problem, they’re symptoms of the problem. The problem is the lack of adequate funding for the health system. For example, when people can’t have a cataract procedure done in a timely fashion, if they can’t have that hip replaced, if we don’t have sufficient financial resources to pay for health practitioners or to pay for services, obviously things happen that really are quite unintended.

I believe the government has an obligation. If they’re going to hold the hospitals in this province accountable—if they want them to enter into accountability agreements—they also have to ensure that the hospitals receive adequate funding in order that they can deliver those services to the people who are in desperate need. There’s no point having provisions in an accountability agreement that cannot be achieved if the hospitals are not getting adequate funding. I believe there is an overriding responsibility on the part of the government to let the hospitals know ahead of time as to the amount of money they can anticipate they’re going to receive over a three-year period, and they’re going to have to fund the system adequately. This bill does not make any commitment to fund the system in an adequate manner in order that the provisions of the accountability agreements can be met.

The Chair: Any further speakers?

Mr Klees: I’d like to support my colleague in this amendment. I’d like to speak briefly on behalf of those hospitals that are located particularly in high-growth areas within our province, York region being one of them, and in fact the entire GTA. It’s one thing, as Ms Witmer indicated, for the ministry to say, “You have to bring in your budget within certain parameters.” If the government, the Ministry of Health, is not giving due consideration to the increased pressure on that hospital organization, this bill is simply going to confuse issues and will not do what it was intended to do to begin with.

This is the other side of the accountability issue. It’s one thing to hold hospitals accountable, but what is going to hold the government accountable? Again, I believe that without this amendment, without putting this consideration into effect in this bill, we have a serious problem on the horizon.

Ms Smith: I believe this motion is outside the scope of this legislation. This legislation does not deal directly with funding, and “adequate funding” is such a broad term that I think it would be impossible to define. We’ll be voting against this motion, as it is not actually included in the scope of this legislation.

Ms Martel: We heard from many representatives, particularly of hospital boards, who said that accountability is a two-way street. If the government wants to force hospital boards to be accountable in terms of the services they provide and account for the funding for the same, then the government, by the same token, has to be accountable in terms of providing the necessary funds to make sure those services and programs can be offered. So I believe the issue of funding is at the heart of the accountability agreements, and it does have to be a two-way street.

If we’re going to hold hospitals accountable for the money we provide them and the services they then provide to the community as a result, the government also has to be held accountable to ensure that the necessary funding is in place to allow that to happen. I think funding is an integral part not only of section 3 but also of supporting medicare itself, so I support the motion.

The Chair: Are there any further speakers?

Seeing none, those in favour? Those opposed? That motion is lost.

We move on to page 4: Ms Witmer.

Mrs Witmer: I move that the bill be amended by adding the following section:

“Protection of personal information

“1.1 Where any provision of this act conflicts with any provision of a law of Canada or another law of Ontario concerning the protection of personal information, the law of Canada or the other law of Ontario prevails.”

We want to be absolutely certain that the personal information of individuals in this province is protected, and we want to ensure the supremacy of Bill 31, in order that Ontarians can be guaranteed—as you know, this bill, as originally written, gave huge, unprecedented power to

the minister to access personal information. I think the government realized they had made a terrible mistake. I think it speaks to the hasty manner in which this legislation was drafted. We just want to be absolutely certain that any private information related to personal health information of Ontarians is protected and that Bill 31 will be supreme.

The Chair: Any further speakers?

Ms Smith: Bill 31 will revoke subsections 14(6) and 15(3) of Bill 8, so there's no longer any question that Bill 31 prevails over Bill 8. As a result, there's no conflict between the bills. If there were a conflict between Bills 8 and 31, Bill 31 would indeed prevail. I hope that reassures Ms Witmer of her concerns with respect to the supremacy of Bill 31.

With respect to federal legislation, it should not prevail in an area of provincial jurisdiction.

Mrs Witmer: What were the motions that would speak to that?

Ms Smith: I believe it's part of Bill 31. It's the way Bill 31 is written. If you'd like a more technical briefing on that, I can have our legal counsel advise you.

Mrs Witmer: But there are no amendments within this legislation. Are you revoking parts of this legislation?

Ms Smith: No. It's the way this bill is drafted in tandem with Bill 31.

Mr Klees: Mr Chair, I have a hard time simply accepting that.

The Chair: Let's be clear. Ms Witmer, you had the floor. Do you need a further explanation? If not, I will go to Mr Klees.

Mrs Witmer: Yes, I would like a staff explanation.

Ms Smith: Certainly. Ms Witmer, if you would turn to page 21 with respect to section 13, I'm happy to have legal counsel advise you on this.

Mrs Witmer: And perhaps they could just review that with us.

The Chair: Absolutely. Would somebody like to come forward who is best equipped to deal with that?

Ms Laurel Montrose: I apologize, Ms Witmer, I don't have the exact section of Bill 31 that does this. I can't locate it at this moment, but I'll look for it for you.

That bill has already been through clause-by-clause, and it contained two sections, both of which revoke the sections in question. I'll endeavour to find them for you in Bill 31 and let you know, but that has already been completed.

Mr Klees: If I could just get clarification: Are we being told that Bill 31 is revoking sections in Bill 8?

Ms Montrose: That's correct.

Mr Klees: Why would there not be something at this table revoking those sections? I don't understand.

Ms Montrose: I think the intention was to deal with this early on in the process. Because Bill 31 went to committee and through clause-by-clause before Bill 8, it was put forward at that time.

1040

Mr Klees: But that bill hasn't been enacted, so how can you say that Bill 31 has done anything to this bill?

Ms Montrose: You're correct that it hasn't been enacted. But when and if it is enacted, as currently written, it will have that impact; it will revoke these two subsections.

Mr Klees: Why would we rely on that? Can you make a presumption that Bill 31 will be passed?

Ms Montrose: Mr Klees, I'm just a lawyer here. I can tell you that the impact of Bill 31 as it's currently drafted will revoke these two subsections when enacted.

Mr Klees: But we don't know if it's going to be enacted.

Ms Montrose: I can't answer that question.

Mr Klees: Then let me ask you this question: As a lawyer, given the fact that Bill 31 may not be enacted, would it not be prudent for us, as a committee dealing with Bill 8, to take the action at this table to ensure that this bill does what the government intends?

Ms Montrose: I think that calls upon me to speculate as to what will be enacted and when. I can simply say that, when enacted, Bill 31 as drafted will revoke these two subsections.

Mr Klees: Well, Chair, I submit to you that I think it would fall to this committee to deal with Bill 8. We cannot presume that Bill 31 is going to be enacted. Why should this committee simply defer to another bill that's out there when it's our responsibility as a committee to ensure that this bill does what it's intended to do? So I'd call on the parliamentary assistant to make a motion now to take the necessary steps with regard to Bill 8, so that this matter can be resolved before we move forward.

The Chair: Thank you, Mr Klees. Are there any further speakers?

There being none, all those in favour of this motion? Those opposed? The motion is lost.

We move on to page 5, which is a government motion.

Ms Smith: I move that subsection 2(7) of the bill be amended by striking out "or a senior staff member" and substituting "or the chief executive officer or an officer".

The Chair: Speaking to the motion? Ms Martel.

Ms Martel: If I might, Chair, I even recall during the course of the public hearings that at least one presenter from a hospital board made the point that they wouldn't be allowed to sit on the health quality council as a result of this section, and they were quickly assured by the government that "member of the board" was of a health system organization, and the example of the OHA was even used to reassure the presenter that this didn't mean volunteer members of local hospital boards. I would really urge the government to take a step back on this particular section and recognize that it doesn't make a whole lot of sense to force people to choose between making a contribution on a local hospital board as a volunteer and having the potential to sit on the health quality council—having to choose.

If the government meant, as they answered that presenter at the time, that this was only a reference to the

OHA or other political organizations representing health care stakeholders, then the government should make good on that commitment here. I don't see any reason whatsoever to exclude volunteer local hospital board members from the possibility and the potential of sitting on the health council, to have to forgo one in order to do the other.

Mrs Witmer: Again, we support it; we spoke to it before. The hospital board volunteer is often the person who, at the grassroots level, has more insight as to the needs of the local community, the people in the province, than many other person. I think it would be so inappropriate that, with the years of volunteer experience that individual has, at the end of the day they would have to make a choice and give up one in order to do the other.

I get the impression that this particular piece of legislation is really weighted heavily against hospitals and hospital boards and staff in Ontario, and I think this particular section really does speak to that.

Mr Klees: Chair, I would like the government, probably the parliamentary assistant, to give us an explanation as to what has happened between the time—this committee in public hearings, as Ms Martel indicated, was given the assurance that this section would not apply to volunteer members of boards. Now, after all of this consultation, in spite of hearing submissions from across the province, we are back to this and we've put volunteer members of boards back in. I would like to understand, and I'm sure members of the public would like to understand, what has happened and why the government is taking this action.

The Chair: Ms Smith, do you have a response?

Ms Smith: As we already discussed, we're not precluding the board members from sitting on the council; we're just asking them not to do it at the same time. If they'd like to be on the council, they are more than welcome. We'd just ask them not to sit on the board of their hospital at the same time, in order to avoid a conflict of interest, in order to allow them to represent a broader interest.

Mr Klees: With respect, that was not the understanding we were given by the government during hearings, and I'd be interested to know now what has moved the government to take the position that volunteer members of boards would find themselves in a conflict. Do they not believe that these highly qualified people have the ability to take into consideration their responsibilities to the council and keep in perspective these matters of conflict that the parliamentary assistant is speaking to? I'd just like to know what has convinced them now that these volunteer board members would not be capable of carrying out this responsibility?

Ms Martel: May I just get some clarification? In respect of this amendment to the earlier one that we passed, does that also mean that, for example, board members of a not-for-profit, community-based health organization—access aides, palliative care—can't sit as well if they are a member of the board? Do they have to give up their position as volunteers, or is this restricted to hospital board members?

The Chair: Let's get that clarified. Ms Smith, would you answer that, or would you like to call somebody forward?

Ms Smith: I think we'll call somebody forward.

The Chair: OK. Who from staff would be the best equipped to answer the question of Ms Martel? Would you come forward and introduce yourself.

Ms Paula Kashul: My name is Paula Kashul, counsel with the Ministry of Health.

The definition in the proposed amendment that was already dealt with added “a health resource provider within the meaning of part III.” In the current bill it's section 19, and there is also a motion to amend that section at page 36 of your motions.

Mrs Witmer: Are you referring to section 19 now?

Ms Kashul: Section 19. That section is proposed to be replaced by a later motion, on page 36. In the proposed amendment, a health resource provider includes “a hospital within the meaning of the Public Hospitals Act ... a private hospital ... a psychiatric facility ... an institution within the meaning of the Mental Hospitals Act ... an approved corporation within the meaning of the Charitable Institutions Act,” that is, one of the long-term-care facilities, “a municipality or a board of management” for homes for the aged—again, that's a long-term-care facility—“a licensee under the Nursing Homes Act”—again, a long-term-care facility—“a licensee under the Independent Health Facilities Act, or ... a community care access corporation....” Then it goes on to exclude certain individuals. Those are the health resource providers who, when you get to that motion, are proposed to replace section 19.

1050

The Chair: So specifically, some of the examples that Ms Martel gave would or would not be covered?

Ms Kashul: If I could just ask you to repeat, what was the one question that you had?

Ms Martel: My interest was board members of community-based health service organizations: AIDS groups, the hepatitis C group we heard from. Those representatives, as I read this—

Ms Kashul: As you read that, they would not be caught by that definition. Therefore, they would be eligible to be members.

Ms Martel: OK. But anybody else who is on a board of a hospital, psychiatric facility, any long-term-care facility, including municipal, charitable and for-profit—

Ms Kashul: If this motion is passed, yes.

Ms Martel: And community care access centres—all of those people would be excluded in the sense that they have to resign their position on the board in order to serve on the council.

Ms Kashul: Right, it's a board member. Currently, subsection 2(7) talks about a board member or a senior staff. This motion proposes to change that so the board member is not touched—it stays—and we replace senior staff with chief executive officer or other officer of the organization.

Ms Martel: Then, may I just add to my concern, because originally I didn't read this well enough and was thinking just hospital board. We're looking at thousands and thousands of people who operate essentially as volunteers—I want to make that distinction, because it's the volunteer group that I am conscious of—who make a contribution in their community, who would be asked to forgo being able to do that in order to sit on the council. For the life of me, I can't understand why the government is moving in that direction to exclude volunteers on these many, many boards across the province.

That's all I'll say, Chair.

The Chair: Any further comments?

Those in favour? Those opposed? That motion is carried.

Shall section 2, as amended, carry? Those in favour? Those opposed? Section 2 is carried.

Section 3: There are no amendments. Is there any debate on section 3?

Shall section 3 carry? Those opposed? That is carried.

Moving on to page 6, section 4: Ms Witmer.

Mrs Witmer: I move that subclause 4(a)(i) of the bill be amended by striking out "access to" and substituting "quality and accessibility of." This refers to the functions of council.

It says here that "The functions of the council are, (a) to monitor and report to the people of Ontario on...."

We're suggesting that instead of just saying "access to publicly funded health services," that be changed to read, "monitor and report to the people of Ontario on the quality and accessibility to publicly funded health services."

I guess the one thing we want to make sure of is that this particular council has the opportunity to ensure that patients in this province are receiving care of the highest standard. We also want to make sure that the entire issue of patient safety is addressed, and we want to make sure that this health council is truly serving the needs of the people in this regard. We believe it must be given the power to monitor and report on the quality of and accessibility to publicly funded services in Ontario. As presently written, the council does not have that mandate. Unless it's expanded, we don't believe it is going to serve the needs of Ontarians, as it obviously should.

Mr Klees: I just want to add that given the fact that we're referring to this as the health quality council, I think Mrs Witmer's amendment certainly makes a great deal of sense.

The Chair: Further speakers?

There being none, all those in favour of the motion on the floor? Those opposed? That motion is lost.

Page 7: Mrs Witmer.

Mrs Witmer: Yes, section 4. I move that section 4 of the bill be amended by adding the following subsection:

"Evidence-based research

"(2) In carrying out its functions, the council may build on the evidence-based research of other organizations."

Again, I think it's extremely important that the council have the ability to monitor and report on quality, which has just been voted down by the government, regrettably. They also need to monitor and report on accessibility. But I think they also need to be able to take into consideration that there is a lot of good work that has been done by other organizations and they need to have access to that evidence-based research. It might be research that has been undertaken by bodies such as the Institute for Clinical and Evaluative Sciences and other organizations, but I certainly think they need to take that into consideration.

I also think we could avoid duplication if they were in a position to access this evidence-based research. That would also encourage more collaboration and synergy between the various organizations in this province. If they are going to do their work well, they need to have access to some of the data that has already been collected. I think that is critical to their role of monitoring and reporting, and it will allow them to look at quality.

The Chair: Any further speakers to the motion?

Ms Smith: I just wanted to note that certainly in our discussions with various stakeholders on this particular issue we did state that it would be the intention of the council to review the documents and reports provided by a variety of stakeholder groups and organizations in the province that are working in health care. I don't believe we need the amendment to confirm that intention.

Ms Kathleen O. Wynne (Don Valley West): And in fact, in the regulations, it will be made clear that that's exactly the intention.

Mrs Witmer: If that's the intention, I'm not sure why there is any harm in putting this into the body of the bill, because the amendment simply says: "In carrying out its functions, the council may build..." It doesn't make it a prerequisite. I think it's really important that whatever information has been collected by credible research organizations be taken into consideration, so I don't know why the government would oppose this amendment.

The Chair: Are there any further speakers?

Seeing none, all those in favour? Those opposed? That motion is lost.

Shall section 4 carry?

Ms Martel: I'd like to make a point about section 4. I would encourage the government to take a step back and really promote the council by ensuring that it actually has some teeth and is not just a group of very well-meaning people who do good work only to see their report sit on the shelf. I have said before and I'll say again that I think one of their functions should be to make recommendations to the minister as well. So the section would read: "The functions of the council are to monitor, report and make recommendations to the people of Ontario on" the list that appears there. I think if the government says that it wants to be responsive to medicare and wants to support and enhance, then that group of people who are being set up to do just that should have the additional responsibility, obligation and work to make recommendations to the minister on these matters when they see

there are gaps in the health care system. So I think, clearly, they should have that additional and very important responsibility if they are actually going to be able to do meaningful work on behalf of the people of Ontario.

The Chair: Any further speakers?

Shall section 4 carry? Those in favour? Those opposed? Section 4 is carried.

We move on to page 8. The first motion is a government motion.

1100

Ms Smith: I move that subsections 5(1), 5(2) and 5(5) of the bill be struck out and the following substituted:

“Reports

“(1) The council shall deliver to the minister, “(a) a yearly report on the state of the health system in Ontario; and

“(b) any other reports required by the minister.

“Tabling

“(2) The minister shall table a report under this section in the Legislative Assembly within 30 days of receiving it from the council, but is not required to table the council’s annual business plan.”

Ms Martel: I have a question. Is there some reason why the government would not want to have the council’s annual business plan tabled? It gives the perception that somebody has something to hide, and I don’t know why you’d want to do that.

The Chair: Is there anybody who’s prepared to answer that? Or would you like an answer from staff, Ms Martel?

Ms Martel: I’d be interested in what’s the motivation. Is it that the budget is going to be so obscene you don’t want people to see it? I can’t imagine that.

The Chair: That’s probably not a question for staff. Are there any further speakers?

Ms Martel: There must be a reason, so I’m just curious as to what it is.

Ms Smith: This is not a change, Ms Martel. It was in the original draft as well.

Ms Martel: Well, wait a minute—

The Chair: I’m sure our staff is not going to pass comment as to whether any budget is obscene, but certainly if you have a question of them that is within their capability, I will ask them to come forward and answer it.

Ms Martel: That would be great. I’d like to know why we are not making that information public. What’s the problem?

The Chair: Is staff comfortable in answering that?

Ms Pearl Ing: I’m Pearl Ing.

The Chair: Ms Martel, would you ask the question again, and please try and keep it within the type of question that a staff member can answer.

Ms Martel: Thank you. I will.

The government motion says that the minister shall table the report but he is not required to table the council’s annual business plan. I’m wondering why that is not being presented as well, why that would not be tabled.

Ms Ing: In the normal course of procedure, most agencies do not table their business plans to the Legislature. That would go to Management Board of Cabinet. That was the rationale, that few other agencies—at this point we haven’t worked out how the agency will be structured. That will be done through regulation.

Ms Martel: If I might, most other agencies aren’t reporting annually to the Legislature via the minister either, so there is a difference between this agency and others. Most other health care agencies, you’re right, would not be submitting their budgets to the Legislature, but their reports would also not be tabled in that public a manner either.

Ms Ing: I think the intent is that they want to table the yearly report to the Legislature because it is going to be different from other agencies, but in terms of the sort of yearly operational plans, that would go through the normal process all other agencies go through. That was the intent.

Ms Martel: OK. Thanks.

The Chair: Any further comments?

There being none, all those in favour? Those opposed? That motion is carried.

We move on to page 9: Ms Witmer.

Mrs Witmer: I move that subsection 5(4) of the bill be struck out and the following substituted:

“Recommendations

“(4) In a report under this section, the council may make recommendations to the Legislature.”

If I take a look at this health quality council, I see here the creation of this council as envisioned in this act to be a contradiction to the promise that was made by the Premier in the speech from the throne. It has no power to make recommendations. Furthermore, in the speech from the throne on November 20, it was stated that there would be new legislation “introduced to create a new health quality council.

“This independent council”—and I emphasize the word “independent”—“will report directly to Ontarians on how well their health care system is working—and how well their government is working to improve health care.

“Your new government understands it can only hold others to a higher standard if it subjects itself to the same standard.”

We now see contained within the body of Bill 8 a broken promise, because we no longer have an independent health quality council. We have a health quality council which reports first to the minister and then, in 30 days, the report is tabled. So there isn’t the opportunity as originally envisioned for the council to hold the government accountable for the system.

We’ve now voted down the fact that it can consider the quality of health care, and I’m suggesting that in order to give it some teeth—which it really has not at the present time; it is a toothless council—we at least allow it the opportunity to make some recommendations to the Legislature. I mean, one promise was made; it has now been broken. At least give it some freedom, some

flexibility to report on the quality of the health system, the problems and recommendations for moving forward in order to ensure that the highest standard of care and patient safety is maintained in this province.

The Chair: Any further speakers?

Seeing none, all those in favour? Those opposed? That motion is lost.

Shall section 5 carry, as amended?

Ms Martel: Chair, can I just make a point? The reason I didn't speak to Mrs Witmer's motion is that I think the amendment should say, "shall make recommendations," and I think it should be their requirement. This ties on to the functions that I listed earlier, where I think their mandate should be expanded to monitor, report and make recommendations. If this council is to have any teeth at all, is to have any force in terms of making the government accountable to the findings in their various reports and through their various monitoring activities, then there has to be some obligation on the part of the government to also accept recommendations from the council and actually deal with them, implement them.

As it stands now, I worry that we will have a group of very well-intentioned, well-meaning people who will do a great deal of work, only to see their work sit on a shelf, and I don't think that's going to serve anyone very well. So I think that in addition to changing the functions of the council, which would include recommendations, the council should also be making recommendations not just with respect to future areas of reporting, as appears in the bill—and it now appears that the government wants to keep that section—but also that allow them to do their work so that any area of health care policy, legislation, gaps in health care may be an item for them to make recommendations on, and that they should have to do that.

The Chair: Any further speakers?

There being none, shall section 5 as amended carry? Those in favour? Those opposed? Section 5 is carried.

Moving on to page 11: Mrs Witmer, section 6. I'm sorry; I'm one page ahead of myself. Page 10: Ms Smith.

Ms Smith: I move that section 6 of the bill be amended by striking out clauses (a) and (c) and substituting the following:

"(a) governing the council's constitution, management, structure and legal status;

"(f.1) regarding the nature and scope of the yearly report required by section 5."

The Chair: Seeing no speakers, those in favour of the motion? Those opposed? That motion is carried.

Mrs Witmer.

Mrs Witmer: I move that clauses 6(1)(h) and (i) of the bill be struck out. Again, this amendment builds on a previous amendment, where we want to ensure the supremacy of Bill 31, which has not yet been approved. It has just finished clause-by-clause after first reading. We want to again be absolutely certain and confident that the privacy and personal information of Ontarians are protected. These sections obviously would no longer be required if Bill 31 is proclaimed.

1110

The Chair: Further speakers?

Ms Smith: With respect to Bill 31, Ms Witmer had requested the provisions within Bill 31 which reflect Bill 8 and how they're drafted in tandem. Subsection 77(1) of Bill 31 addresses that concern. If you'd like, I can read it into the record or I can just give you a copy.

"77(1) This section applies only if Bill 8 (An Act to establish the Ontario Health Quality Council ...) ... receives royal assent.

"(2) References in this section to provisions of Bill 8 are references to those provisions as they were numbered in the first reading version of the bill.

"(3) On the later of July 1, 2004, and the day on which subsection 14(6) of Bill 8 comes into force, subsection 14(6) of the Commitment to the Future of Medicare Act, 2003, is repealed.

"(4) On the later of July 1, 2004, and the day on which subsection 15(3) of Bill 8 comes into force, subsection 15(3) of the Act is repealed."

The Chair: Are there further speakers?

Seeing none, those in favour of the motion? Those opposed to the motion? That motion is lost.

On to page 12, still on section 6.

Mrs Witmer: I move that section 6 of the bill be amended by adding the following subsection:

"Referral to Legislative Assembly

"(3) Every regulation made under this section shall be referred to the Legislative Assembly and reviewed by a committee of the Legislative Assembly."

This would ensure and give some confidence to the people in the province of Ontario, particularly those people who are impacted by this legislation, that the stakeholders would have every opportunity to review the regulations and make suggestions prior to the regulations becoming law. It also demonstrates what the government continues to talk about: that they want a collaborative and transparent approach to government. This recommendation certainly would ensure transparency and collaboration.

Ms Smith: The government motion at page 13, new section 6.1, will address public consultation before making regulations. I believe it will address the concerns raised by Ms Witmer.

Mrs Witmer: It will but it won't. I don't think there's an opportunity for it to come back to committee. I think it reads that notice is going to be given and people have an opportunity to comment, but there will not be any public discussion of these regulations within a committee. So it won't be a very transparent process at all.

The Chair: Are there any further speakers?

Seeing none, those in favour? Those opposed? That motion is lost.

Shall section 6 carry, as amended? Those in favour? Those opposed? Section 6, as amended, carries.

Section 6.1 on page 13, a government motion.

Ms Smith: I move that the bill be amended by adding the following section:

"Public consultation before making regulations

“6.1(1) Subject to subsection (7), the Lieutenant Governor in Council shall not make any regulation under section 6 unless,

“(a) the minister has published a notice of the proposed regulation in the Ontario Gazette and given notice of the proposed regulation by all other means that the minister considers appropriate for the purpose of providing notice to the persons who may be affected by the proposed regulation;

“(b) the notice complies with the requirements of this section;

“(c) the time periods specified in the notice, during which persons may make comments, have expired;

“(d) the minister has considered whatever comments and submissions that members of the public have made on the proposed regulation, or an accurate synopsis of such comments; and

“(e) the minister has reported to the Lieutenant Governor in Council on what, if any, changes to the proposed regulation the minister considers appropriate.

“Contents of notice

“(2) The notice mentioned in clause (1)(a) shall contain,

“(a) a description of the proposed regulation and the text of it;

“(b) a statement of the time period during which a person may submit written comments on the proposed regulation to the minister and the manner in which and the address to which the comments must be submitted;

“(c) a description of any other methods by which a person may comment on the proposed regulation and the manner in which and the time period during which they may do so;

“(d) a statement of where and when members of the public may review written information about the proposed regulation;

“(e) any prescribed information; and

“(f) any other information that the minister considers appropriate.

“Time period for comments

“(3) The time period mentioned in clauses (2)(b) and (c) shall be at least 60 days after the minister gives the notice mentioned in clause (1)(a) unless the minister shortens the time period in accordance with subsection (4).

“Shorter time period for comments

“(4) The minister may shorten the time period if, in the minister’s opinion,

“(a) the urgency of the situation requires it;

“(b) the proposed regulation clarifies the intent or operation of this part or the regulations; or

“(c) the proposed regulation is of a minor or technical nature.

“Discretion to make regulations

“(5) Upon receiving the minister’s report mentioned in clause (1)(e), the Lieutenant Governor in Council, without further notice under subsection (1), may make the proposed regulation with any changes the Lieutenant

Governor in Council considers appropriate, whether or not those changes are mentioned in the minister’s report.

“No public consultation

“(6) The minister may decide that subsections (1) to (5) should not apply to the power of the Lieutenant Governor in Council to make a regulation under section 6 if, in the minister’s opinion,

“(a) the urgency of the situation requires it;

“(b) the proposed regulation clarifies the intent or operation of this act or the regulations; or

“(c) the proposed regulation is of a minor or technical nature.

“Same

“(7) If the minister decides that subsections (1) to (5) should not apply to the power of the Lieutenant Governor in Council to make a regulation under section 6,

“(a) those subsections do not apply to the power of the Lieutenant Governor in Council to make the regulation; and

“(b) the minister shall give notice of the decision to the public as soon as is reasonably possible after making the decision.

“Contents of notice

“(8) The notice mentioned in clause (7)(b) shall include a statement of the minister’s reasons for making the decision and all other information that the minister considers appropriate.

“Publication of notice

“(9) The minister shall publish the notice mentioned in clause (7)(b) in the Ontario Gazette and give the notice by all other means that the minister considers appropriate.

“Temporary regulation

“(10) If the minister decides that subsections (1) to (5) should not apply to the power of the Lieutenant Governor in Council to make a regulation under section 6 because the minister is of the opinion that the urgency of the situation requires it, the regulation shall,

“(a) be identified as a temporary regulation in the text of the regulation; and

“(b) unless it is revoked before its expiry, expire at a time specified in the regulation, which shall not be after the second anniversary of the day on which the regulation comes into force.

“No review

“(11) No action, decision, failure to take action or failure to make a decision by the Lieutenant Governor in Council or the minister under this section shall be reviewed in any court.”

The Chair: Speaking to the motion?

Ms Martel: In order to be consistent with the comments I made on Bill 31, which has a section that is somewhat similar—not exactly the same—in terms of the regulation-making process, let me just say that I see no need for subsection 11, either the section that appeared in Bill 31 with the same sort of references or here, that, “No action, decision, failure to take action or failure to make a decision by the Lieutenant Governor in Council or the minister under this section shall be reviewed in any

court." In the case of Bill 31 it also says that no review shall be undertaken by the Freedom of Information and Privacy Commissioner, but I understand why that doesn't apply here.

I think that it leaves the perception that the government has something to hide, and I don't know why the government would want to put itself in that position of having a reference in there in the regulation-making section. It seems to me that if the government feels confident and comfortable about the process it's using to develop regulations and about the regulations themselves, there is absolutely no need for a provision that essentially says that any failure to take action cannot be reviewed by a court. I'm not sure why the government wants to go in that direction, and as I said on Bill 31, I really think you should take that section out.

The Chair: Any further speakers?

Seeing none, those in favour? Those opposed? The motion is carried.

Moving on to page 14, section 7.

Mrs Witmer: I move that the bill be amended by adding the following subsection:

"Waiting times

"7.1 In the interest of increasing health"—

1120

The Chair: I'm sorry, I'm ahead of myself again. It seems to be the way things are moving this day. We need to deal with section 7 where there are no proposed amendments. Would somebody like to speak to section 7?

Seeing no speakers, those in favour of the motion? Those opposed? Section 7 is carried.

Mrs Witmer, the floor is yours again.

Mrs Witmer: I move that the bill be amended by adding the following section:

"Waiting times

"7.1 In the interest of increasing health care accessibility, the minister shall act to ensure that waiting times for treatment are reasonable."

Part II refers to health services accessibility. I think if we take a look at the issue of accessibility, at the present time we don't have the accessibility, obviously, that we are looking for. The minister has a responsibility to ensure, if we are going to proclaim that people have accessibility, that we take a look at the wait times for treatment and that those wait times are reasonable. To talk about accessibility and not talk about wait times, I think, does a disservice to the people of Ontario.

I go back to what I said before. If, as the minister proclaimed on the day this bill was introduced that he wanted to stop queue-jumping and two-tier and everything else, the reality is, folks, that is a symptom of a problem, and that is that people are waiting too long. If the government is truly committed to medicare, improving accessibility to health care services, it must reduce wait times, and it must address that issue within this bill.

The campaign promise was that they were going to work with the experts to set and meet the maximum needs-based waiting times for care. I think this bill, in its

commitment to medicare, needs to reflect reasonable waiting times for treatment.

Ms Smith: I believe the minister, in his opening statement to this committee, did note that the Ontario Health Quality Council could assist in monitoring on specific wait times with respect to specific health services. I therefore think that some of the concerns the member raises will be addressed through the reports of the Ontario Health Quality Council.

Mrs Witmer: I understand, but the key word there is "may," and the other key concern I have is that the committee doesn't have the ability to make recommendations. So regardless of what they discover about wait times or quality of care, it really is a council that has no teeth to make any recommendations in order to reduce the wait times and make sure that our health care system is accessible.

The Chair: Any further speakers?

Seeing none, all those in favour of the motion? Those opposed to the motion? That motion is lost.

Section 8: No amendments are being proposed. Shall section 8 carry? Those in favour? Those opposed? Section 8 is carried.

Moving now to page 15: a government motion on section 9.

Ms Smith: I move that subsections 9(1), (2) and (4) of the bill be struck out and the following substituted:

"Persons not to charge more than OHIP

"(1) A physician or designated practitioner shall not charge more or accept payment or other benefit for more than the amount payable under the plan for rendering an insured service to an insured person.

"Exception

"(1.1) Subsection (1) does not apply to,

"(a) a charge made to or a payment or benefit accepted from a public hospital for an insured service rendered to an insured person in that public hospital;

"(b) a charge made to or a payment accepted from a prescribed facility for an insured service rendered to an insured person in that facility; or

"(c) any other charge, payment, benefit or service that is prescribed, subject to any prescribed conditions or limitations.

"Physicians and designated practitioners

"(2) A physician or designated practitioner shall not accept payment or benefit for an insured service rendered to an insured person except,

"(a) from the plan, including a payment made in accordance with an agreement made under subsection 2(2) of the Health Insurance Act;

"(b) from a public hospital or prescribed facility for services rendered in that public hospital or facility; or

"(c) if permitted to do so by the regulations in the prescribed circumstances and on the prescribed conditions.

"Restriction on who may accept payment

"(4) No person or entity may charge or accept payment or other benefit for rendering an insured service to an insured person,

“(a) except as permitted under this section; or

“(b) unless permitted to do so by the regulations in the prescribed circumstances and on the prescribed conditions.

“Not a payment or other benefit

“(4.1) For the purposes of subsection (4), ‘payment or other benefit’ does not include a salary or an amount payable under a contract of employment or a contract of services to an employee of or a person who contracts with a physician, practitioner, public hospital or prescribed facility.”

The Chair: Any speakers?

Ms Martel: I have a question. We heard from a number of hospitals and physicians about the various payment methods that are in place, particularly in hospitals, to recruit and retain physicians. I’m going to assume there are any number of them and that clause (1.1)(c), “any other charge, payment, benefit or service that is prescribed,” is the section that’s going to catch everybody we might miss. Am I correct in that?

Ms Smith: Yes. This section allows for the payment of hospitalists. That concern was raised by a number of presenters in our travels.

Ms Martel: In Sudbury, one of the psychiatrists who does work through a CHC gets a payment that way. I just want to be clear that the ministry is looking at (c) as the mechanism by which any plans we don’t know about are actually going to be caught and then covered.

The Chair: Would somebody like to come forward and clarify that?

Ms Montrose: Yes, the authority is there to prescribe quite broadly. So if it’s not captured by “a public hospital” in (a) or “a prescribed facility” in (b), the regulation-making authority in (c) is quite broad.

The Chair: Are there any further speakers?

Those in favour of the motion? Those opposed? That motion is carried.

Shall section 9, as amended, carry?

Those in favour? Those opposed? That motion is also carried.

It appears there are no amendments to section 10. Is there a speaker to section 10?

Ms Martel: I have a question. I understand that this section was lifted from a previous bill, so the wording that appears in section 10 is essentially the wording that appeared when the original bill, the Health Care Accessibility Act, was adopted.

We did, however, hear from representatives of other regulated health professions who looked at this section and assumed they were excluded from the possibility of negotiating with the government around fees. I thought there was some sympathy, from what we were hearing from the groups, that we should either (a) not specifically reference some of the groups or (b), as an alternative, reference all the regulated health professions so it would be clear that the government may enter into agreements with respect to fees for the whole range of regulated health professions.

Because I don’t see an amendment coming forward from the government, I wonder what the decision was, then, not to try to allay some of the fears of the groups who came before us by either specifically referencing everybody or not referencing only some of the group of regulated health professionals.

The Chair: Let’s go to Ms Smith first, and do you need to call somebody forward, Monique?

Ms Smith: Absolutely. Subsection 10(3) of the legislation, as drafted, allows for those agreements to be made between the regulated health professionals and the minister.

Ms Martel: I understand that, but that was also in place in the original bill. Even with that in place, it was clear that there was not only a bit of confusion but also a great deal of concern about who might be included and who was excluded. We heard from a couple of chiropractic groups, and I think we also heard from the dental hygienists, who thought they were excluded. I could be wrong about the dental hygienists, but a separate regulated health profession thought they were excluded. Is there some huge problem, in terms of drafting, that would very clearly and concisely cover those groups that need to be covered—those groups the government clearly does enter into agreements with through the regulated health professions in terms of fees being paid for services rendered?

1130

Ms Smith: Again, as we responded to the chiropractors and others who came to present to us, the reason for the drafting is to keep consistency within the legislation. Subsection 3 allows for those agreements to be reached, and there wasn’t a sense that the amendments needed to be made.

Ms Martel: I’ll just close by saying that I think we should. I’m not sure what you mean by consistency with the rest of the legislation. The dilemma is that we are dealing with a 1986 piece of legislation that didn’t make it clear, and I think we should now.

The Chair: Any further speakers on section 10?

Actually, I don’t think anyone has moved it yet. Ms Smith, would you like to move section 10?

Ms Smith: I move section 10.

The Chair: Apparently we don’t need to, but thanks anyway.

Ms Smith: No problem.

The Chair: All those in favour? Those opposed? Section 10 is carried.

Moving on to section 11, page 16: a government motion.

Ms Smith: I move that subsection 11(1) of the Bill be struck out and the following substituted:

“Unauthorized payment

“(1) If the general manager is of the initial opinion that a person has paid an unauthorized payment, the general manager shall promptly serve on the physician, practitioner, other person or entity that is alleged to have received the unauthorized payment notice of the general manager’s intent to reimburse the person who is alleged

to have made the unauthorized payment, together with a brief statement of the facts giving rise to the general manager's initial opinion.

"Providing information"

"(1.1) The physician, practitioner, other person or entity that is alleged to have received the unauthorized payment may, not later than 21 days after receiving the notice described in subsection (1), provide the general manager in writing with any information that he, she or it believes is relevant to determining whether an unauthorized payment has been paid.

"Payment by general manager"

"(1.2) If, after reviewing any information provided in accordance with subsection (1.1), the general manager is satisfied that a person has paid an unauthorized payment, the general manager shall pay to the person the amount of the unauthorized payment."

The Chair: Are there any speakers?

Seeing none, those in favour? Those opposed? That motion is carried.

We move on to page 17, the same section.

Ms Smith: I move that subsection 11(2) of the bill be amended by striking out "subsection (1)" and substituting "subsection (1.2)".

The Chair: Speaking to the motion?

Those in favour? Those opposed? That motion is carried.

Moving on to page 18.

Ms Smith: I move that subsection 11(5) of the bill be amended by striking out "subsection (1)" and substituting "subsection (1.2)".

The Chair: Any speakers?

Those in favour? Those opposed? That motion is carried.

Finally, on section 11, page 19.

Ms Smith: I move that subsection 11(6) of the bill be amended by striking out "subsection (5)" and substituting "subsection (1) or (5)".

The Chair: Any speakers?

Seeing none, all those in favour? Those opposed? That motion is carried.

Shall section 11, as amended, carry?

Those in favour? Those opposed? Section 11 is carried.

Moving on to section 12: There are no amendments before me. Shall section 12 carry?

Those in favour? Those opposed? That is carried.

Moving on to page 20, section 13.

Ms Smith: I move that subsections 13(1), (2) and (3) of the bill be struck out and the following substituted:

"Personal information"

"(1) The general manager may directly or indirectly collect personal information, subject to such conditions as may be prescribed, for purposes related to the administration of this part, the Health Insurance Act or the Independent Health Facilities Act.

"Use of personal information"

"(2) The general manager may use personal information, subject to any conditions that may be prescribed, for

purposes related to the administration of this part, the Health Insurance Act or the Independent Health Facilities Act.

"Disclosure"

"(3) The general manager shall disclose personal information if all prescribed conditions have been met and if the disclosure is necessary for purposes related to the administration of this part, the Health Insurance Act, the Independent Health Facilities Act, the Regulated Health Professions Act, 1991 or a health profession act as defined in that act, but shall not disclose the information if, in his or her opinion, the disclosure is not necessary for those purposes.

"Limitation"

"(3.1) The general manager shall not collect, use or disclose more information than is reasonably necessary for the purposes of the collection, use or disclosure."

The Chair: Speaking to the motion?

Seeing none, all those in favour? Those opposed? That motion is carried.

Page 21: Ms Smith.

Ms Smith: I move that section 13 of the bill be amended by adding the following subsections:

"(5) Subsection (6) only applies if Bill 31, An Act to enact and amend various acts with respect to the protection of health information, which received first reading on December 17, 2003, receives royal assent.

"(6) On the later of the day this subsection comes into force and the day on which Bill 31 receives royal assent, clause (4)(b) is amended by adding 'or the Personal Health Information Protection Act, 2004' at the end."

The Chair: There is a clarification. Is that on the "later" of the day or on the "latter" of the day?

Ms Smith: You say "later"? Sorry. Later.

The Chair: The "tomato" or "tomatto" thing.

Ms Smith: Exactly.

The Chair: Speaking to the motion that's on the floor?

Seeing none, those in favour? Those opposed? That motion is carried.

Shall section 13, as amended, carry?

Those in favour? Those opposed? That motion is carried.

Moving on to page 22: section 14, Ms Smith.

Ms Smith: I move that subsection 14(1) of the bill be struck out and the following substituted:

"Disclosure of information to the general manager"

"(1) The general manager may require that any person or entity submit information to the general manager for the purposes of determining whether there has been a contravention of or a failure to comply with any of the following provisions, if the general manager is of the opinion that such a contravention or failure may have taken place:

"1. Section 9, 11, 15 or 16 of this act.

"2. Section 15 or 15.1 of the Health Insurance Act.

"3. Section 3 of the Independent Health Facilities Act."

The Chair: Any further speakers?

Seeing none, those in favour? Those opposed? That motion is carried.

Moving on to page 23, Ms Smith.

Ms Smith: I move that subsection 14(2) of the bill be amended by striking out “that he or she requires” and substituting “is necessary for the purposes mentioned in subsection (1).”

The Chair: Any speakers?

Seeing none, those in favour? Those opposed? That motion is carried.

Page 24.

Ms Smith: I move that subsection 14(3) of the bill be struck out and the following substituted:

“Time and form

“(3) Subject to the regulations, the information shall be submitted and disclosed,

“(a) in the form required by the general manager; and

“(b) within 21 days of the receipt by the person or entity of the request by the general manager.

“Extension of time

“(3.1) The general manager may extend the period of time mentioned in clause (3)(b) for a time that the general manager believes is reasonable in the circumstances if the general manager believes that the person or entity cannot submit or disclose the information within the prescribed time for reasons that he, she or it cannot control.”

Ms Martel: Chair, I have a question. Is the choice of 21 days a practice now? The original bill didn’t have any information with respect to timing. I just don’t know how you arrived at that. Is it some kind of general practice? Was this agreed to by the general manager? If I could just get that clarification, that would be great.

Ms Smith: I believe it was in discussions in the stakeholder group and the general manager. It was agreed to as being an appropriate time.

Ms Martel: When you say, “stakeholder group,” do you mean the OMA or the College of Physicians and Surgeons or both?

Ms Smith: The OMA.

The Chair: Those in favour of the motion on page 24? Those opposed? That motion is carried.

Page 25: Ms Smith.

Ms Smith: I move that section 14 of the bill be amended by adding the following subsection:

“No retaliation

“(7.1) No person or entity shall discipline or penalize any person for reporting, providing or disclosing information under this section unless he or she acts maliciously and the information is not true.”

1140

Ms Martel: I just want to be clear that the intention is to protect any and all whistle-blowers here. Originally I was concerned that it appeared that people more in a senior management capacity or a senior capacity would be protected, and maybe I was wrong in my assumption about that. But I want to be clear that this section is really to capture everybody who might come forward.

Ms Smith: Yes, it is to extend the whistle-blowing provision and certainly in defining “any person for reporting,” I think that extends that protection to those you are concerned about.

The Chair: All those in favour? Those opposed? That motion is carried.

Page 26.

Ms Smith: I move that the definition of “provincially funded health resource” in subsection 14(9) of the bill be struck out.

The Chair: Speaking to the motion?

Seeing none, all those in favour? Those opposed? That motion is carried.

Shall section 14, as amended, carry?

Those in favour? Those opposed? Section 14 is carried.

Moving on to page 27: section 15.

Ms Smith: I move that section 15 of the bill be amended by adding the following subsections:

“No retaliation

“(4.1) No person or entity shall discipline or penalize any persons for making a report under subsection (2) or for providing information in connection with the report unless the person who reported or provided the information acted maliciously and the information is not true.

“Defence

“(4.2) Where an employer or contractor is charged with contravening subsection (1) as a result of an act committed by an employee, subcontractor or person with whom the employer or contractor contracted, it is a defence to the charge that the employer or contractor took all reasonable steps in the circumstances to prevent such a contravention.”

The Chair: Any comments?

Seeing none, all those in favour? Those opposed? That motion is carried.

Shall section 15, as amended, carry?

Those in favour? Those opposed? That is carried.

Moving on to page 28: section 16.

Ms Smith: I move that subsection 16(1) of the bill be struck out and the following substituted:

“Block fees

“(1) A person or entity may only charge a block or annual fee in accordance with the regulations.”

The Chair: Any speakers?

Seeing none, all those in favour? Those opposed? That motion is carried.

Shall section 16, as amended, carry?

Those in favour? Those opposed? Section 16 is carried.

Section 16.1, an official opposition motion.

Mrs Witmer: I move that part II of the bill be amended by adding the following section:

“Wait-times

“16.1(1) The Ontario Health Quality Council shall regularly conduct surveys to determine the actual wait-times for various health services.

“Where significant wait-time

“(2) For services where a significant wait-time is documented, the council shall refer the services to a sub-committee of the council to be known as the Scientific Advisory Committee, which shall review the matter and recommend the maximum reasonable wait-time for each service.

“Where exceeds

“(3) Where the council finds that the actual wait-time for a service in a community exceeds the maximum reasonable wait-time, the council shall report that fact to the minister.

“Minister to work

“(4) The minister shall work with the health care providers in the community to establish goals and a work plan to reduce the waiting times, and the goals and work plan shall be a matter of public record.

“Report

“(5) At least twice in every year, the minister shall report to the Legislature on provincial compliance with the maximum reasonable wait-times.”

I guess we introduce these amendments because we are now dealing with the section within Bill 8 that concerns health service accessibility. We do know that the government has indicated that in this legislation they want to make a commitment to medicare. A big part of the problem today is the lack of accessibility, whether it's because of a lack of health care professionals to deliver the services or whether it's inadequate funding or having services and programs available to people in all parts of Ontario. I think it really is important that we make sure that no matter where you live in this province, you have access to the service that is needed. That's why I think it is so important to document the wait-times. Nowhere in this bill, which purports to be concerned about accessibility, do we address or identify the issue of wait times as being important to accessibility. So I think these amendments are extremely important.

Again, this council, which now isn't going to be independent, at least needs to have the scope of its mandate broadened. It needs to deal with what I know many people in this province believe to be the most important issue, and that is accessibility. The greatest impediment today to accessibility is the issue of wait-times.

The Chair: Any further speakers?

Seeing none, all those in favour of the motion? Those opposed? That motion is lost.

Moving on to section 17 on page 30.

Ms Smith: I move that subsections 17(2), (3), (5) and (6) of the bill be struck out and the following substituted:

“Penalty, individual

“(2) Subject to subsection (2.1), an individual who is convicted of an offence under this section is liable to a fine of not more than \$10,000.

“Same, subsection 15(2)

“(2.1) An individual who is convicted of an offence under this section for contravening subsection 15(2) is liable to a fine not exceeding \$1,000.

“Penalty, corporation

“(3) A corporation that is convicted of an offence under this section is liable to a fine not exceeding \$25,000.

“Limitation

“(5) A prosecution for an offence under this section shall not be commenced after two years after the date on which the offence was, or is alleged to have been, committed.”

The Chair: Any speakers?

Seeing none, all those in favour? Those opposed? That motion is carried.

Shall section 17, as amended, carry?

Those in favour? Those opposed? That motion is carried.

Moving on now to page 31: section 18.

Ms Smith: I move that clause 18(1)(g) of the bill be struck out and the following substituted:

“(g) governing the information that must be provided under section 14, including its content and the form in which it must be provided.”

The Chair: Any speakers?

Seeing none, all those in favour? Those opposed? That motion is carried.

Page 32: Ms Smith.

Ms Smith: I move that subsection 18(1) of the bill be amended by adding the following clause:

“(h.1) prescribing conditions and limitations for the purposes of this part.”

The Chair: Any speakers?

Seeing none, all those in favour? Those opposed? That motion is also carried.

Page 33: Mrs Witmer.

Mrs Witmer: I move that section 18 of the bill be amended by adding the following subsection:

“Referral to the Legislative Assembly

“(5) Every regulation made under this section shall be referred to the Legislative Assembly and reviewed by a committee of the Legislative Assembly.”

Because of the far-reaching impact of this bill and certainly the possibility for the stakeholders not to have adequate opportunity to respond to the regulations that may at some later time be put in place by the government, and the fact that there isn't any opportunity for, I guess, the openness and transparency that the government believes should be there, we just want to ensure that the stakeholders and those concerned people in Ontario have the opportunity to review the regulations. We want not only to make sure they have the opportunity to make suggestions, but we want to know that the government is seriously considering those suggestions and recommendations that are being made. We believe that in order to make sure that there is transparency, co-operation, openness, this amendment is necessary.

1150

Mr Klees: I want to support my colleague in putting this amendment forward. I have to believe that at least the more reasonable members of the government sitting on this committee today—I look at Mr Leal, certainly Mr Delaney, Mr Duguid—would support this. It's going to

take a majority vote to ensure this is done. I can tell you that this is not just the opposition bringing forward this amendment; the request has been made by stakeholders that they have an opportunity to review these regulations.

I didn't make any comment with regard to, for example, the amendment being proposed around block fees, because it was referred to regulations. But I also don't want to trust the government—because I don't think we have a lot of reason to—to bring forward the appropriate regulations. I'm assuming, for example, that with regard to block fees, the College of Physicians and Surgeons will still have their prescribed responsibility around that issue, but we won't know that until we see the regulations. That is just one example.

I would look forward to the government, at least in this one amendment—they have not voted for one very reasonable amendment that's been put forward by the opposition yet today. There's a trend developing here, Mr Chair, that I'm sure is disturbing to you as well, that all of the good consultation that's taken place with stakeholders is falling on deaf ears for members of the government here today. So at least I would expect that this one would pass.

The Chair: Are there any other speakers?

Ms Smith: We'd just like to note that we have provided that provision for part I. However, with respect to this part, there are some timeliness issues with respect to implementation of changes around OHIP fee structures. That's the reason we're not providing that kind of consultation process on the regulations for this particular part of the bill.

Mr Klees: Mr Chair, I can't tell you how absolutely disappointed we are that we would not take the time to give stakeholders the appropriate opportunity to review these very important regulations. Surely we could call a special session of the committee—I would certainly be willing to do that—to ensure that we're not driven by some other timelines here. Let's do it through spring break if we have to. Let's make sure that we do what has to be done to have a good piece of legislation and that the regulations in fact do what is intended. I'd ask the parliamentary assistant to reconsider her response.

The Chair: Thank you, Mr Klees. Are there any further speakers?

Seeing none, all those in favour of the motion? Those opposed? That motion—

Mr Klees: On every one, I think we should have a recorded vote.

The Chair: —is lost.

Mr Klees: I'd like a recorded vote on that last amendment, please.

The Chair: Let me confer with the clerk. Oddly enough, we did have a discussion about this.

OK, a recorded vote has been called for.

Ayes

Klees, Martel, Witmer.

Nays

Delaney, Duguid, Leal, Matthews, Smith, Wynne.

The Chair: That motion is lost.

Shall section 18, as amended, carry?

Those in favour? Those opposed? That is carried.

Section 19, page 34: Ms Smith.

Ms Smith: I move that the definitions of “executive function or position” and “primarily an executive function or position” in section 19 of the bill be struck out.

The Chair: Any speakers?

Seeing none, those in favour? Those opposed? That motion is carried.

Page 35: Ms Smith.

Ms Smith: I move that section 19 of the bill be amended by adding the following definitions:

“chief executive officer” means any individual who holds the position of chief executive officer with a health resource provider, and any individual who, regardless of title,

“(a) holds a position with a health resource provider similar to that of chief executive officer, or

“(b) performs functions for a health resource provider similar to those normally performed by a chief executive officer; (‘chef de la direction’)

“compensation package” means the value of any compensation in any form that is provided to or on behalf of a chief executive officer in respect of his or her office with a health resource provider including,

“(a) any amount that is required by section 5 of the Income Tax Act (Canada) to be included in the chief executive officer’s income from his or her office with the health resource provider;

“(b) any amount or benefit paid to or on behalf of another person arising directly or indirectly from the chief executive officer’s position with or services provided to the health resource provider; and

“(c) any other prescribed compensation type; (‘rémunération’)

“performance agreement” means an agreement between a health resource provider and a chief executive officer of the health resource provider under this part; (‘convention de performance’).

Ms Martel: I'd just like to ask a general question, because we're heading into an essential rewrite of part III and we've got the definitions that are going to relate now to various sections within part III. Before we get there, can I just be clear that the bill will still allow the minister to claw back various forms of compensation of a chief executive officer? Can I get that clarification right now?

The Chair: I believe you can.

Ms Smith: There are amendments being provided around that process that we will be reviewing in the very near future.

Ms Martel: I understand that, but I want to be consistent in how I vote through this section. Can I just get an answer now as to whether or not somewhere in the amendments that are coming the government or the

minister is still going to have the capacity to claw back compensation of a hospital CEO?

The Chair: Can we point to the section?

Ms Smith: I would refer Ms Martel to section 26.1, which is at page 60 of your package. The Lieutenant Governor in Council may make an order under subsection (5).

Ms Martel: Thanks.

The Chair: Are there any further speakers to the motion on pages 35(a) and (b)?

Seeing none, those in favour? Those opposed? That motion is carried.

Page 36: Ms Smith.

Ms Smith: I move that the definition of "health resource provider" in section 19 of the bill be struck out and the following substituted:

"'health resource provider' means,

(a) an entity that operates,

(i) a hospital within the meaning of the Public Hospitals Act,

(ii) a private hospital within the meaning of the Private Hospitals Act,

(iii) a psychiatric facility within the meaning of the Mental Health Act, or

(iv) an institution within the meaning of the Mental Hospitals Act,

(b) an approved corporation within the meaning of the Charitable Institutions Act that operates and maintains an approved charitable home for the aged,

(c) each municipality or a board of management maintaining a home for the aged or a joint home for the aged under the Homes for the Aged and Rest Homes Act,

(d) a licensee under the Nursing Homes Act,

(e) a licensee under the Independent Health Facilities Act, or

(f) a community care access corporation within the meaning of the Community Care Access Corporations Act, 2001.

"but does not include a physician or practitioner, as defined in the Health Insurance Act, or a group of physicians or practitioners, in his, her or its capacity as a physician, practitioner or group that receives any payment for the provision of an insured service to an insured person under the Health Insurance Act, or a trade union; ('fournisseur de ressources en santé')."

Mr Jeff Leal (Peterborough): Just a question to the parliamentary assistant: This goes a long way to relieve the concerns that have been raised by CUPE during their presentations. I have the response from them.

Ms Smith: Absolutely. This addresses the concerns that were raised by a number of trade union and worker organizations with respect to whether the accountability agreements will apply to trade unions.

1200

The Chair: Any further speakers?

Seeing none, those in favour? Those opposed? That motion is carried.

Moving on to page 37: Ms Smith.

Ms Smith: I move that the definition of "provincially funded health resource" in section 19 of the bill be struck out.

The Chair: Any speakers?

Seeing none, all those in favour? Those opposed? That motion is carried.

Shall section 19, as amended, carry?

Those in favour? Those opposed? Section 19 is carried.

Moving on to section 20 on page 38: Mrs Witmer.

Mrs Witmer: I move that section 20 of the bill be amended by striking out the portion before paragraph 1 and substituting the following:

"In administering this part, the minister shall be governed by the public interest and by the principle that accountability of the government and of health resource providers is fundamental to a sound health system, and shall consider the importance of those of the following matters that the minister, in his or her discretion, determines to be appropriate in the circumstances."

This is the part that refers to the matters under consideration, and we believe it's extremely important to introduce this amendment, because again, it does, I think, speak loudly to the fact that accountability is a two-way street. There is an accountability on the part of the ministry, the minister, as well as the health resource providers, and this ensures the accountability.

It also ensures—because nowhere does it state this—that within part III the minister is required to act in the public interest when implementing performance agreements. We believe it's absolutely essential that the reference to public interest be made here. As we know, the precedent for that obligation can be found in the Public Hospitals Act.

It states:

"9.1(1) In making a decision in the public interest under this act, the Lieutenant Governor in Council or the minister, as the case may be, may consider any matter they regard as relevant including, without limiting the generality of the foregoing...."

Then it goes on to say,

(a) the quality of the management and administration of the hospital;

(b) the proper management of the health care system in general;

(c) the availability of financial resources for the management of the health care system and for the delivery of health care services;

(d) the accessibility to health services in the community where the hospital is located; and

(e) the quality of the care and treatment of patients."

Further, as stated above, accountability must—and I stress "must"—extend to both the providers and the government, and in that respect I believe this amendment is very, very important.

Ms Martel: Chair, if I might, section 20 sets out the matters that have to be considered in developing the accountability agreement, and that has to be in the public

interest. So I support it both in this amendment and in the government amendment that comes next.

The Chair: Making everybody happy. Are there any further speakers?

Ms Smith: I would like to thank Ms Martel for her fairness in supporting both motions, and I would note for Mrs Witmer that in our government amendment on page 39 we are addressing the public interest and in fact reflecting the language that's in the Public Hospitals Act. So I think our amendments, both in the preamble, as you'll see later, and on page 39, address all the concerns you're raising through this amendment.

Mrs Witmer: I'll withdraw my amendment then.

The Chair: That amendment has been withdrawn, so let's move on to page 39.

Ms Smith: I move that section 20 of the bill be struck out and the following substituted:

“Governing principle

“20(1) In administering this part, the minister shall be governed by the principle that accountability is fundamental to a sound health system.

“Public interest

“(2) The minister and the Lieutenant Governor in Council may exercise any authority under this part where he, she or it considers it in the public interest to do so and, in doing so, the minister or the Lieutenant Governor in Council may consider any matter that he, she or it considers relevant in the circumstances, including any of the following:

“1. Clear roles and responsibilities regarding the proper management of the health care system and any health resource provider.

“2. Shared and collective responsibilities.

“3. Transparency.

“4. Quality improvement.

“5. Fiscal responsibility.

“6. Value for money.

“7. Public reporting.

“8. Consistency.

“9. Trust.

“10. Reliance on evidence.

“11. A focus on outcomes and the quality of the care and treatment of individuals.

“12. Any other prescribed matter.”

The Chair: Speaking to the motion?

Seeing none, all those in favour? Those opposed? That motion is carried.

Shall section 20, as amended, carry?

Those in favour? Those opposed? Section 20 is carried.

Moving on to section 21 on page 40.

Ms Smith: I move that section 21 of the bill be struck out and the following substituted:

“Accountability agreements

“21(1) The minister may give notice to a health resource provider that,

“(a) the minister proposes to enter into an accountability agreement with the health resource provider; or

“(b) the minister proposes to enter into an accountability agreement with the health resource provider and one or more other health resource providers.

“Discussion

“(2) The minister and the health resource provider shall negotiate the terms of an accountability agreement and enter into an accountability agreement within 60 days after the notice under subsection (1) is given.

“Information

“(3) The minister and the health resource provider shall disclose to each other any information, other than personal information, that they consider necessary for the purposes of negotiating an accountability agreement, but this subsection does not,

“(a) authorize or require the minister to disclose information that is not required to be disclosed to a requester under the Freedom of Information and Protection of Privacy Act;

“(b) authorize or require a health resource provider to disclose information that is not required to be disclosed to a requester under the Municipal Freedom of Information and Protection of Privacy Act, if that act applies to a health resource provider;

“(c) authorize or require the disclosure of any information that is subject to any privilege recognized by law; or

“(d) require the disclosure of any information that the minister or health resource provider is entitled not to disclose by virtue of any other law.

“Direction

“(4) If the health resource provider and the minister do not enter into an accountability agreement within 60 days after the minister gave notice under subsection (1), the minister may direct the health resource provider to enter into an accountability agreement with the minister and with any other health resource provider on such terms as the minister may determine, and the health resource provider shall enter into and shall comply with the accountability agreement.

“Performance agreement

“(5) An accountability agreement may provide that a health resource provider will enter into a performance agreement with its chief executive officer to support the achievement by the health resource provider of the terms of the accountability agreement.

“Same

“(6) If an accountability agreement requires that a health resource provider enter into a performance agreement, the health resource provider and its chief executive officer shall enter into a performance agreement within such period of time stipulated in the accountability agreement, and the terms of the performance agreement shall be consistent with the accountability agreement.

“Exception—chief executive officer

“(7) Despite subsection (6), a chief executive officer shall not be required to enter into a performance agreement except with respect to that part of the individual's appointment, employment or contract that relates to his or her function or position as a chief executive officer for the health resource provider.

"Duty of health resource provider

"(8) A health resource provider has a duty to take all reasonable care to ensure that its chief executive officer complies with any performance agreement and his or her duties under this part, including taking such measures as may be necessary from time to time to enforce the health resource provider's rights under the performance agreement."

Ms Martel: I have a question about subsection (4), direction, where it says that the minister may direct the provider to enter into an accountability agreement on such terms as the minister may determine, and the health provider shall enter into that agreement. My concern is if that process doesn't happen.

I flip to the next government amendment, which is a new section, which certainly talks about an arbitrator, which I assume refers back to subsection (4), which would be the process that kicks in if subsection (4) doesn't work. But I'd like some clarification that that is what has happened.

My second question would be, why wouldn't there be a reference in subsection (4) to the next government amendment that comes that talks about an arbitration process?

Ms Smith: At page 48, new section 21.1, we set out the due process provisions for the minister to issue a directive. You'll see the first one is that, "A health resource provider has not entered into an accountability agreement as directed by the minister under subsection 21(4)." It then goes on to outline the process that's in place before the minister would issue a directive.

1210

Ms Martel: But why wouldn't subsection (4) of the section, which we have just dealt with, make a reference to another provision somewhere else in the bill that clearly outlines what's going to happen? If you read this section, just on the face of it without having a reference to anything else, it clearly says that the minister may direct. Then it clearly says that the health resource provider shall enter into and comply with the accountability agreement. If you read that section by itself with no other reference, it doesn't outline what process happens. It certainly doesn't outline a process that may require an arbitrator rather than unilateral imposition of an accountability agreement on the health resource provider. I think there should be something in subsection (4) that even makes some kind of reference to other sections in the bill where it is clear that this would not be imposed but there would be some kind of arbitrated process.

Ms Smith: The next section in the legislation, as we're proposing be amended—21.1 refers in subsection (1) to 21(4), which is the section that you're referring to, and sets out the due process that's in place to allow the minister to issue a directive.

Ms Martel: I understand that, and that's how I figured out there was going to be some other kind of process versus an imposition. But I don't see what the problem would be in having some kind of reference in this particular section that gives you an indication of what is coming in terms of an arbitrated process.

As you go through this and you follow, as the bill is set out, the first thing that would strike you, if you just look at that section by itself, is that the minister is going to essentially impose something if the health resource provider and the minister don't come to some amicable terms before that. I would just think that there's got to be some way that there's a reference in this section that a more positive outcome might be coming somewhere else in terms of the process.

Ms Smith: Again, I just refer you to the next section where we reference back. Do I understand, Ms Martel, that you're looking for a reference forward as opposed to a reference back?

Ms Martel: Yes.

Ms Smith: Perhaps the drafters could enlighten us as to why we're not referencing forward.

Mr Robert Maisey: I'm Robert Maisey, counsel with the Ministry of Health and Long-Term Care. I think it's just a drafting convention. The intention is to impose in subsection (4) an obligation to enter into an accountability agreement if it's not negotiated. Then section 21(1), which is proposed on page 48, indicates what happens in a variety of different circumstances if various obligations under part III are not followed, one of which is that the "provider has not entered into an accountability agreement as directed," and then it continues. Section 21.1 does not address an arbitration process.

Ms Martel: On the face of it, it wouldn't address any process at all, which would let you come to the conclusion that it's going to be imposed. If it's not going to be imposed, I'm not sure the government wants to leave that impression there.

Ms Smith: I think, as the member opposite knows, no legislation is read with one specific clause without reading the rest. It all hangs together, and that's why the next section refers back to 21(4).

Ms Martel: If I might, we just went through a process on Bill 31 where there were any number of references backwards and forwards, if that's the best term we can use here, any number of areas where there were relations back to other sections, whether they came after or whether they were before the changes. I would think it would be in the government's interest to find a way that it could be clear that something else happens here other than a unilateral imposition. I leave that with the government.

Mrs Witmer: We're now into the whole part III, accountability, and I can tell you, I continue to have very grave reservations about this section. I know the stakeholders have grave reservations about this section. Despite the fact that I know there was some consultation with stakeholders, I think they believe this does not respond to the concerns they raised, and I think that for the government to pretend this reflects a compromise or reflects some of the points that were made would not be accurate.

Probably the whole crux of this bill is contained within part III. The rest is just a shell, but the real goal of the government is here. I don't think there's any attempt

made here to continue to support hospital boards having the governance role that they presently enjoy. In essence, this section, this whole part III, in many ways really does reduce hospital boards to advisory boards. I would have expected the government to spend a little bit more time listening to the stakeholders and trying to respond, unless, as I said at the outset, there's an ulterior motive and a reason to move forward in this way.

Let me just speak to this, because if you take a look at this, folks, there has been no change made. At the end of the day, you've got this 60-day period. If there has not been an agreement reached between the two parties, then it still directs the hospital to sign an accountability agreement that will be unilaterally imposed. There is no statement here that indicates that both parties will agree; it's going to be unilaterally imposed after 60 days.

Well, if that's the case, it will effectively strip hospital boards in your communities of much of the authority they enjoy today. They will not be in a position any longer to make the fundamental decisions about health care services on behalf of their community; the government, the ministry, will be making those decisions. I think that's what this bill is intended to do: take the power away.

If you really care about your hospital board, if you respect the people in your community who have worked so hard on behalf of that community and know first-hand what's needed in your community, you've got to respect the role those boards have had; you've got to make sure you can preserve voluntary governance as it exists today. We have to make sure that if the parties have not been able to reach a negotiated accountability within the 60-day period or where there's an issue respecting compliance with the agreement, any remedial action that is taken—for example, here it's suggesting imposing or enforcing the agreement. I believe the government needs to take a look at making sure you can only impose remedial action by means of an order by the Lieutenant Governor in Council acting in the public interest. That is the only way we're going to be able to protect the interest of local communities.

Proceeding by way of an order in council will ensure that both the board and the ministry will be motivated to come to an agreement and resolve any issues they might have in the best interests of your local community. It's not going to be one-size-fits-all, whether you live in northern Ontario, in Toronto or Ottawa or in a little community such as Clinton.

If you look at having an order by the Lieutenant Governor in Council acting in the public interest, it will also ensure that the powers of the minister are not abused or delegated to non-elected ministry officials.

It's also consistent with the Public Hospitals Act today—today. When we appoint the investigators and the supervisors, it must be done by way of an order in council, so why would we be suggesting anything less in this particular section? So I am going to vote against, in particular, subsection (4). I don't know when it is appropriate, but I would like to substitute an amendment to subsection 21(4).

The Chair: If you were to provide that in writing right now, Ms Witmer, we could deal with it. I'm sure we could get it copied for you, if need be.

I'm going to suggest we take about a two- or three-minute break while we get this copied. I can't wait to see this go through the machine.

The committee recessed from 1222 to 1229.

The Chair: If we can come back to order again, we are actually going to be dealing with two amendments to the amendment that was put forward by Ms Smith, the government motion on page 40. We're going to start with one. Everybody should have one before them. There will be another one that follows this. I propose to deal with it as one amendment to the amendment that will either pass or fail, deal with the second amendment to the amendment, and then deal with the amendment itself. Right now we're dealing with government amendment subsection 21(4).

Mrs Witmer: I move that subsection 21(4) of the bill be struck out and the following substituted:

"21(4) If the health resource provider and the minister do not enter into an accountability agreement within 60 days after the minister gives notice under subsection (1), the minister may refer the matter in writing to the Lieutenant Governor in Council who, acting in the public interest, may make an order setting the terms of the accountability agreement."

I go back to what I said before: In the present direction that is given, if there is no negotiated agreement at the end of 60 days, the minister has the power to unilaterally impose an agreement. I am very concerned, as I know people in this province are, that that would effectively strip power from the boards of hospitals in this province and take away their ability to make the critical decisions that are necessary on behalf of their community. I believe that if we're going to ensure that the boards continue to have the opportunity to reflect the will of the local constituents, we must make this change.

I guess the other concern I have is that if we don't allow for this to happen in this way, through the Lieutenant Governor in Council, there is the possibility that the best interests of the community would not be considered. It would allow, as I said before, that this authority to make an agreement could end up in the hands of non-elected ministry officials. Again, if you take a look at the appointment of supervisors and investigators in this province in the Public Hospitals Act, that decision, at the end of the day, is made by an order in council. I don't know why we would do anything less in these accountability agreements, if you really believe in local boards and in responding to local needs.

Ms Martel: First of all, apologies to the committee, because I was looking at "arbitrator." I thought I was looking at a government motion making reference to an arbitrator at a later date, so that process could be in place. There doesn't seem to be anything in the government amendments that actually does refer to an arbitrated process. So my apologies, because as I look at it now, I was reading Mrs Witmer's amendment, which I would support.

But I have trouble with the amendment that Mrs Witmer just put forward, because it still makes reference to the Lieutenant Governor in Council, who essentially is the cabinet, to make an order. I could be reading this wrong, but that would be my read of the amendment. That would still not satisfy me, because I think the route that should be taken, both in terms of setting up an accountability agreement and then in any disagreement about whether the terms and conditions of that agreement are met, should be matters that can be dealt with independently by a third party.

Through this whole section, if I might, I would be making the argument that there should be room, when there is no agreement, for the parties to take that dispute to an independent third party. I don't consider the Lieutenant Governor in Council to be that. I would have to say that as it stands and as I read it, I can't support what has been put forward, because I think there should be some place here for arbitrated settlements. Both parties at the end of the day might not like it, but the imposition of something, I trust in the public interest, would then be done by neither of the parties but by an independent adjudicator/arbitrator looking at all of the facts before him or her.

The Chair: Just so we're all clear, is there an amendment coming up from the government that speaks to an arbitrated process or an arbitrator? There isn't? OK. I just wanted to clarify that.

Speaking to the amendment, Ms Smith.

Ms Smith: At the risk of being repetitive, I note that we did spend a lot of time speaking to stakeholders on this bill after first reading, not only in these hearings but the minister and the ministry staff have spent a great deal of time meeting with stakeholders who will be deeply affected by some of this legislation. I would note the stunning similarity in the provisions that Mrs Witmer has put forward to the OHA provisions that I have had the privilege of seeing over the last few days and months in discussions with the OHA. There was a process, there was a discussion, there was negotiation. The provisions that we bring forward reflect those negotiations, those discussions and the input we've received from a variety of stakeholders, including those who presented to this committee.

I believe that our provisions allow for a negotiated agreement. We allow for due process should an agreement not be reached between the health provider and the minister. We also have a provision now with respect to the public interest, which Mrs Witmer seemed most concerned about. In my discussions with hospital administrators and hospital boards, they seemed willing to accept the notion of accountability agreements and the protections that are being put in place through these provisions.

I think we've gone a long way to address the concerns of a number of our stakeholders and that the amendments we have brought forward here for section 20 and that we will be bringing forward in sections 21 and 21.1 address most of the concerns you've raised, Mrs Witmer. I

believe that at the end of the day we will agree to disagree on some of it.

I believe one of my colleagues may have other comments.

Mr Brad Duguid (Scarborough Centre): Just briefly, I wanted to comment on the suggestion that the boards are going to be advisory only. Nothing could be further from reality. The boards will continue to do what they do and do it well. But at the end of the day, this government is committed to reforming this health care system, and if there are some health care providers who are not willing to go along with our plan of reform, then there is going to have to be some accountability within the system. At some point in time, under very rare circumstances, the government will have to assert itself in that respect. I don't think this government in any way is going to be apologetic for doing that. The previous government tried and failed to reform the health care system adequately. This government will not fail. We're determined to get the job done, but we're going to need the tools to do that.

Some 99% of health care providers across this province agree with the need to bring forward reforms and will work with us to do that. But we do need provisions to deal with the very small percentage of health care providers who may not go along as willingly as the others, and that's why we have to move forward in this way.

Sixty days, two months, to negotiate an agreement is an abundant amount of time to get both parties on side, working together. At the end of those 60 days we're going to have to bring forward the changes we need to bring to this system, and we would expect the majority of health care providers will be on side; those few are not, yes, the minister will have to move forward with an accountability agreement.

1240

Mr Leal: We certainly heard a lot this morning about the expertise that is inherent on volunteer boards in hospitals. During my 18 years in municipal politics in the city of Peterborough, I had the opportunity to spend about nine years on the former St Joseph's Hospital board. One of the things I learned from that experience was, just as Mrs Witmer and Ms Martel have articulated this morning, that these people have a tremendous amount of expertise in the community. They come from various backgrounds to bring that expertise to the board, and 60 days is a reasonable time frame for people who have expertise, have knowledge in that area to come about to a satisfactory conclusion.

I want to remind people here that I was on a hospital board when Duncan Sinclair was making his tour of Ontario during the restructuring commission. Let me tell you, there was a hell of a lot less time than 60 days that he was demanding on behalf of a former government for local boards to make decisions about the future in the community. So 60 days is a reasonable amount of time, and reasonable people will come up with a solution within those 60 days.

Mrs Witmer: Notwithstanding what I've heard, I think it's important to put on the record that no one has a problem with accountability agreements. I think everybody recognizes the fact that there is a need for accountability agreements, but certainly, it needs to continue. Accountability needs to continue not to be a one-way street. I guess what is being suggested here is that, for some reason, there cannot be an agreement negotiated within 60 days, and sometimes there are circumstances which would prevent that from happening.

Right now, we don't even know what type of template the government is going to be looking at. I think there needs to be an opportunity for further discussion, further debate at the cabinet table, where people have the opportunity to bring forward some of the concerns that they might hear from their local community. This eliminates that totally. There's no opportunity to speak on behalf of your local community. This agreement will be imposed unilaterally by the ministry at the end of 60 days.

I've been around here long enough to know that there are some who would like to do away with hospital boards. I'm not sure that this isn't the first step in eliminating hospital boards as we know them today and reducing them to mere advisory boards. That means, I guess, that the ministry will assume all responsibility and will just grow the bureaucracy here and will no longer have input into the decisions, the needs of communities throughout Ontario. I don't know why the government is so reluctant to consider making a change to the negotiation of these agreements in order that the public interest is better served.

Ms Martel: As we listen to people on this bill, there is no doubt that there wasn't any single group that said they didn't support accountability agreements, hospital board members included. But I think we all have to agree that we heard all of those groups also say those agreements had to be negotiated; they could not be imposed. Because if they were imposed, then the local boards would clearly see their role as nothing more than advisory bodies taking direction from the ministry. I don't think I am wrong in my assessment of what I heard from many presenters over the two weeks of public hearings. These had to be negotiated.

If you look at section 21.4, at the end of the day, it's clear that these will not be negotiated if an agreement cannot be arrived at. Despite what the minister told this committee, despite what the minister has said publicly about these being negotiated, at the end of 60 days, if there is no agreement, they will be unilaterally imposed by the minister.

Mr Leal is right: There were extraordinary and broad powers given to the Health Services Restructuring Commission, which I opposed, under Bill 26. But I have to tell you, the language that I see here and the language that is coming up with respect to the clawback of CEO compensation also is a demonstration of excessive and arbitrary powers of the minister. I'm not sure why, after the experience of Bill 26, the new government wants to

go there. Why do you want to be seen as having some arbitrary, extraordinary power to essentially take over a hospital? That's what you do when you impose an accountability agreement that is not negotiated or do a clawback from an employee of a hospital board who is the CEO. I suggest you really don't want to go there, if you don't want to be labelled or put into the same category as the previous government with their Bill 26.

I don't care who put forward the solution about a dispute resolution mechanism or an arbitrator. I don't care if it was the OHA, I don't care if it was Mrs Witmer, I don't care if it was one local board that came forward. I think that is the solution that makes much more sense than this legislation, where the minister can impose a solution. Through that process, both of the parties will have to feel that whatever is arrived at is arrived at independently in the public interest. I think the government moves down absolutely the wrong direction here by continuing to allow, even in these amendments, the opportunity for the minister to unilaterally impose a solution.

I think you need to just step back from this and take another good look at why you can't have an arbitrated settlement. If, as most people have argued from the government side, most hospital boards will enter willingly into these agreements and a positive solution will be found that is negotiated and agreed upon, then what is the harm, in those cases where that process breaks down, to have it dealt with by an independent third party?

I cannot encourage you or urge you enough to get rid of any of the arbitrary powers that are listed here that are quite contrary to negotiations and a negotiated settlement and to look for a dispute resolution mechanism or an arbitration process which gets the government out of making an order, imposing orders or taking over a board. Have an independent third party, and I think the results, for those boards you might be having trouble with, will be much better than if the government is seen in a community to be taking over a board or imposing solutions that are not acceptable to a local board.

Ms Smith: I would just again state that we are not in any way questioning the ability of boards to direct their hospitals. We are not in any way affecting their ability to run their hospitals. I would again point the members to section 22, where, in order for a minister to issue a compliance directive, there is a timeline set out, a process set out and a dispute resolution process set out. While it doesn't include an arbitration provision, it does set out a dispute resolution process.

The Chair: Any further speakers? Seeing none—just so we're clear, we are voting on the amendment to the amendment, which is on page 40. You have the amendment before you, moved by Mrs Witmer.

All those in favour? All those opposed? I'm afraid that amendment loses.

I did lead you astray when I told you that we had two amendments to this amendment. The next amendment from the official opposition is actually to section 21(1), so we'll return to the motion that's on page 40. Are there any further speakers? Seeing none—

Mrs Witmer: Recorded vote.

Ayes

Delaney, Duguid, Leal, Matthews, Smith, Wynne.

Nays

Martel, Witmer.

The Chair: The motion is carried.

Moving on to Mrs Witmer, page 41.

Mrs Witmer: I move that section 21 of the bill be struck out and the following substituted:

“Accountability agreements

“21.(1) Subject to subsection (2), the minister and a health resource provided shall, on the request of the Lieutenant Governor in Council, do either or both of the following:

“1. Enter into or renegotiate an accountability agreement.

“2. Enter into or renegotiate an accountability agreement with any one or more health resource providers.

“Due process

“(2) If a request is made under subsection (1), the following process shall be followed:

“1. If the parties mutually agree to the terms and conditions of an accountability agreement, they shall enter into an accountability agreement.

“2. If the parties are unable to mutually agree to the terms and conditions of an accountability agreement within 180 days of the request, or any other time mutually agreed upon by the parties, an arbitrator mutually acceptable to the parties will determine the terms and conditions after receiving submissions from the parties.

“3. If the parties cannot agree on the selection of an arbitrator, each party shall submit a list of three potential arbitrators to a judge of the Ontario Superior Court, who shall select an arbitrator from the lists submitted.

“4. Each party shall be given an opportunity to examine any written or documentary evidence, and a summary of any oral evidence, that another party intends to present to the arbitrator.

“5. Each party shall be given opportunity to make written and oral representations to the arbitrator.

“6. Despite paragraphs 2 to 5, if the parties are unable to mutually agree to the terms and conditions of an accountability agreement, the Lieutenant Governor in Council may, on the written recommendation of the minister, and where satisfied that special circumstances exist and it is in the public interest to do so, make an order to impose an accountability agreement on the parties.

“7. The minister shall cause a copy of the written recommendations of the minister to be delivered to the board of directors of the health resource provider.

“8. The Lieutenant Governor in Council shall not make an order under paragraph 6 sooner than 30 days

after the written recommendation has been delivered to the board of directors.

“9. An accountability agreement that is imposed on the parties under paragraph 6 is binding on the parties.”

1250

I think we can appreciate the need for this type of motion. We've made the point that it needs to be seen that accountability is a two-way street. We want to ensure that elected, appointed or volunteer boards continue to represent the views of their community. I don't think we want to see as much power as we're seeing right now in the hands of the minister. I believe absolutely there is a need for negotiation. Every stakeholder who appeared before us indicated they did support the accountability agreements but they were looking for negotiations. They were looking at an opportunity to continue to give their best advice.

I think what this motion does as well is reaffirm the responsibilities that boards have, and also the CEO. It reinforces the government's respect and support for those who volunteer. I believe, at the end of the day, if you take a look at this proposal, this amendment, it provides for a very fair dispute resolution mechanism.

I go back to what I said before. Take a look at what the government is proposing. If you are directing health resource providers to sign performance agreements, that is totally contrary to a fundamental tenet of contract law that stipulates that parties must enter freely into contracts. Moreover, if you impose an agreement, as the government is suggesting to do, without negotiation, it continues to undermine the role of the board in making those decisions which they have been asked to do on behalf of their community. I think it's an affront to voluntary governance. It undermines that collaborative approach that the government has said it has been looking for since it was elected.

We also know that there was a process underway, during the time that this bill has been introduced, through the JPPC process, where people were looking at developing a multi-year funding framework and performance agreements. That was all supposed to happen based on negotiations. I don't know what's happened to those discussions, but I guess this bill takes away that discussion that was going on and pre-empts it.

I recommend to the government members that you take a look at how you can best serve your communities, consider what input we have received from stakeholders and support this recommendation.

The Chair: Are there any further speakers?

Seeing none, on the motion on pages 41(a) and (b), those in favour? Those opposed? That motion is lost.

I'm going to suggest that prior to getting into any one of the motions—we aren't going to finish all the ones in section 21—perhaps this would be a good time to break. We will recess until 2 o'clock.

The committee recessed from 1256 to 1406.

The Chair: OK. We can call back to order. I've got some very important news for the committee: The Leafs

have acquired Ron Francis, Calle Johansson and Chad Kilger, in case anybody was wondering.

Interjection.

The Chair: Fourth-round draft pick, I think.

Now, back to business. My understanding is we left off at page 41. Ms Witmer, you have a motion to bring forward.

Mrs Witmer: I think, in light of the discussion that has been had, I would withdraw this motion.

Ms Smith: Page 42?

Mrs Witmer: Yes.

The Chair: Page 43: Mrs Witmer.

Mrs Witmer: Likewise, in light of the discussion, I would withdraw that amendment.

The Chair: Page 44.

Mrs Witmer: I move that subsection 21(2) of the bill be struck out and the following substituted:

“Exception

“(2) Despite subsection (1), the minister may not require an individual to enter into any accountability agreement.”

What we’re speaking about is the need for negotiated agreements, the opportunity for the minister to be accountable to the public, the public interest, and we believe that to do anything else undermines that relationship that presently exists between the board and the ministry and the board and the CEO.

The Chair: Any further speakers? We’re on page 44.

All those in favour of the motion? Those opposed? That motion is lost.

Page 45: Mrs Witmer.

Mrs Witmer: I move that subsection 21(2) of the bill be struck out and the following substituted:

“Negotiation and renegotiation of accountability agreements

“(2) An accountability agreement under subsection (1) may be entered into only if the parties to the accountability agreement mutually agree to the terms and conditions of such agreement.

“Arbitrator

“(3) If the parties cannot agree to the terms and conditions of the accountability agreement within 180 days of a request by the minister, or by such other date agreed upon by the parties, an arbitrator mutually acceptable to the parties will determine the terms and conditions of the accountability agreement upon submissions from the parties.

“If cannot agree

“(4) If the parties cannot agree on the selection of the arbitrator, each party will submit a list of three arbitrators to a judge of the Superior Court of Justice and that judge will select the arbitrator to determine the terms and conditions of the accountability agreement upon submissions from the parties.”

Again, this really speaks to what we have been trying to stress throughout our discussion on part III, the accountability piece, and that is giving the two sides the freedom to negotiate these agreements and providing a mechanism by which the parties to the agreement may

resort to a dispute resolution mechanism in circumstances where they have been unable to reach an agreement. I would hope the government is starting to recognize the need to look at a vehicle for dealing with agreements they can’t reach a resolution on.

Mr Klees: I just would like to weigh in on this again, to reinforce the point that Mrs Witmer has made. No one is suggesting that there shouldn’t be an accountability mechanism. What is offensive, frankly, is the unilateral direction the minister seems to want to take in these matters. We cannot—I don’t believe the stakeholders can—understand why the minister wouldn’t be prepared to build some form of meaningful negotiation into this process. I hope that the government will see their way clear to supporting this amendment. It just makes good sense, very consistent with what they say the objective is. 1410

Ms Martel: Very briefly, I agree with the amendment.

The Chair: Thank you. That was very brief. Any further speakers?

Being none, all those in favour?

Ms Martel: Recorded vote.

Ayes

Klees, Martel, Witmer.

Nays

Delaney, Duguid, Leal, Matthews, Smith, Wynne

The Chair: That motion is lost.

We’ll move on to page 46.

Mrs Witmer: Again, I don’t think we can stress enough the need for negotiations in these agreements as opposed to having them unilaterally imposed at the end of 60 days. So I would move that subsection 21(2) of the bill be struck out and the following substituted:

“Due process

“(2) If a request referred to in subsection (1) is made, the following process shall be followed:

“1. The minister shall deliver a notice in writing to the health resource provider setting out the issues to be addressed in the initial or renegotiated accountability agreement, and the proposed terms of the initial or renegotiated accountability agreement.

“2. The parties shall meet within 60 days of delivery of the notice under paragraph 1, or such later date agreed upon by the parties, to determine if they can reach agreement on the matters in the notice.

“3. Each party shall have the opportunity to make written and oral representations prior to the meeting concerning the issues set out in the notice.

“4. Before the meeting, each party shall be afforded an opportunity to examine any written or documentary evidence, and a summary of any oral evidence, to be relied upon by a party.

“5. Each party to the proposed initial or renegotiated accountability agreement shall be provided with the

opportunity to make written and oral representations at the meeting.

“6. If the parties cannot reach an agreement as to the issues described in the notice, upon written recommendation of the minister, the Lieutenant Governor in Council may make an order to impose an initial or renegotiated agreement.

“7. An order under paragraph 6 may be made only where the Lieutenant Governor in Council is of the opinion that exceptional circumstances exist and that it is in the public interest to do so.

“8. The minister shall cause a copy of the written recommendation under paragraph 6 to be delivered to the board of directors of the health resource provider.

“9. The Lieutenant Governor in Council shall not make an order under paragraph 6 earlier than 30 days after the minister’s written recommendation has been delivered to the board of directors of the health resource provider.

“10. If an order is made under paragraph 6 to impose an initial or renegotiated accountability agreement on a health resource provider, such agreement will be deemed to be binding on the parties to the accountability agreement.”

Again, we believe that it is necessary to enter into these accountability agreements. Certainly, the stakeholders who appeared before us all agreed, but the legislation should be providing a mechanism by which the parties to the agreement may resort to a dispute resolution mechanism in circumstances where they have been unable to reach an agreement. Again, I would just encourage the government to seriously consider the unilateral way in which they are asking that these agreements would be imposed after 60 days.

Mr Klees: Chair, I would just ask the parliamentary assistant to provide the committee with a rationale as to why the government would not support this amendment.

Ms Smith: We just passed an amendment at page 40 which addresses a number of the concerns. There are also dispute resolution provisions coming up in the next amendments that we are discussing at page 48. I believe the proposal that Ms Witmer is putting forward is actually cumbersome and more time-consuming than is necessary.

The Chair: Mr Klees, you have the floor.

Mr Klees: I will look for that amendment. I wasn’t aware that you had dispute resolution mechanisms built into your amendment. You’re saying it is there?

Ms Smith: Page 48(b).

Mr Klees: Thank you very much.

The Chair: Are there any further statements on page 46?

Ms Martel: Sorry, I’m trying to quickly read through the section that the parliamentary assistant has referenced. My concern would continue to be that the minister at the end of the day, in spite of the resolution mechanism set out, still has the power to unilaterally impose something. I want to get clarification of that. Is my reading of this correct or incorrect?

The Chair: Ms Smith, can you answer that?

Ms Smith: There is a process on which a directive can be issued.

Ms Martel: I understand there may be a process. My question has to do with whether or not, at the end of the process, the minister has the power to either issue an order or unilaterally impose some kind of circumstance or situation.

Ms Smith: After following due process, yes, the minister can issue an order or a directive.

Ms Martel: Given that, let me just speak briefly to the motion that’s before us and again reiterate my concern with what we heard over and over again, which was that people agreed with accountability agreements but they had to be negotiated, not imposed. I would say to the government that I think your best bet, again, is to be looking at an arbitration process where an independent third party makes the final decision. That takes it out of the hands of the government and, after due notice and due process, the arbitrator, acting in the public interest, would be able to give a ruling. But if you continue down the road where the minister, at the end of the day, has the final say, the powers of the minister will continue to be seen as arbitrary and unnecessary.

Mrs Witmer: Despite the comments made by the parliamentary assistant referring to the process of dispute resolution that they’re introducing, this in no way, shape or form speaks to the due process that I have just outlined. Basically that reserves for the minister the right to enforce or put in place an agreement, and again, the final arbiter is the minister. It’s not a neutral third party. So I don’t think there is an adequate process for dispute resolution. It’s still a very heavy-handed process of making sure at the end of the day, I guess, that the ministry and the minister are able to do whatever they want in issuing an order.

Mr Klees: Having had an opportunity to read the government’s amendment that the parliamentary assistant referred to, seeing as we didn’t get these until very late yesterday afternoon, I agree with my colleagues that certainly the government motion on page 48 does not address what the amendment that’s now before us attempts to deal with. In fact, the government motion is really a lot of window dressing. The right words are used, but there certainly is nothing here that gives us any comfort that the government intends to have good-faith discussion and negotiation, and it certainly leaves all the authority, all the power to make the final decision. So you arbitrate for a while and when the minister is fed up with that, he’ll just make his directive. It’s not what we’re suggesting here at all. So if the government agrees with the spirit that there be arbitration, then they should be supporting this amendment.

1420

The Chair: Are there any further speakers?

Seeing none, all those in favour of the motion? Those opposed? That motion is lost.

Page 47: Ms Witmer.

Mrs Witmer: I move that section 21 of the bill be amended by adding the following subsection:

"Performance agreement"

"(3) An accountability agreement between a health resource provider and the minister may require that the health resource provider enter into an agreement with its chief executive officer concerning his or her performance in that capacity, on terms to be negotiated between the health resource provider and the chief executive officer."

I guess this provision does ensure that each hospital board would have a performance agreement with its chief executive officer.

While I'm on this whole issue of accountability, I have to tell you I'm really quite offended by the news release that's just been put in front of me and was issued by this government at 2:01, where you claim that the amendments that are introducing support and enhance the role of voluntary boards and spell out the four providers that are subject to accountability agreements, and state that the accountability agreements will be negotiated between the board and the minister. That is not accurate.

Mr Klees: Actually, it's worse than not accurate.

The Chair: Are there any further speakers to the motion on page 47?

There being none, all those in favour? Those opposed? That motion is lost.

Shall section 21, as amended, carry? Those in favour?

Ms Martel: Recorded vote.

Ayes

Delaney, Duguid, Leal, Matthews, Smith, Wynne.

Nays

Klees, Martel, Witmer.

The Chair: That motion is carried.

We move on to page 48. That is a government motion.

Ms Smith: This government motion is around compliance directives and the process around those directives.

I move that the bill be amended by adding the following section:

"Notice of non-compliance—health resource provider

"21.1(1) The minister may give notice in writing to a health resource provider where the minister believes that any of the following circumstances have occurred:

"1. A health resource provider has not entered into an accountability agreement as directed by the minister under subsection 21(4).

"2. A health resource provider has not entered into a performance agreement with its chief executive officer as required under subsection 21(6).

"3. A chief executive officer has not entered into a performance agreement with a health resource provider as required under subsection 21(6).

"4. The terms of a performance agreement that a health resource provider and its chief executive officer have entered into or intend to enter into are not consistent

with the terms of an accountability agreement as required under subsection 21(6).

"5. A health resource provider has not complied with a term of an accountability agreement.

"6. A health resource provider has not complied with its duty under subsection 21(8).

"7. A health resource provider has not complied with a term of a performance agreement.

"8. A chief executive officer has not complied with a term of a performance agreement, an order issued under subsection 26.1(5) or any provision of this part that a chief executive officer is required to comply with.

"9. A health resource provider has not complied with a compliance directive, an order issued under section 25, or an order issued under subsection 26(1).

"10. A health resource provider has not complied with any provision of this part.

"Contents of notice"

"(2) A notice under subsection (1) shall briefly describe,

"(a) the circumstance that has led the minister to give the notice; and

"(b) any directions that the minister proposes to make to the health resource provider in a compliance directive or an order under subsection 26(1).

"Process of dispute resolution"

"(3) After receiving a notice under subsection (1), where a health resource provider disputes any matter set out in the notice,

"(a) the minister and the health resource provider shall discuss the circumstances that resulted in the notice or any directions that are proposed in the notice;

"(b) the minister shall provide to the health resource provider any information that the minister believes,

"(i) is appropriate for the minister to disclose to the health resource provider, and

"(ii) is necessary to an understanding of the circumstances referred to in the notice or the directions that are proposed in the notice; and

"(c) the health resource provider may make representations to the minister about the matters set out in the notice.

"Consideration"

"(4) The minister shall consider any representations made under subsection (3) before making a decision to issue a compliance directive or an order under subsection 26(1).

"Exception"

"(5) Subsections (1) to (4) do not apply to the issuance of an order under subsection 26(1) if the minister believes that,

"(a) a circumstance described in subsection (1) exists which urgently requires that an order under subsection 26(1) be issued to a health resource provider and the circumstance is,

"(i) exceptional and unlikely to occur in the future, or

"(ii) causing or likely to cause harm to any person or property;

“(b) it is reasonable not to follow the procedures set out in subsections (1) to (4); and

“(c) it is necessary to issue an order under subsection 26(1) to a health resource provider to remedy the circumstance or alleviate the effects of the circumstance.”

The Chair: We have notice of an amendment that we will deal with first. Just so we could confirm, point 8 on page 48(b) talks about “an order issued under subsection 26.1(5).” Is that number accurate, or can we perhaps confirm that number while we’re discussing the amendment?

Interjection.

The Chair: OK, the number is accurate. I think Hansard may have heard 21.5.

Ms Smith: Sorry.

The Chair: It should be 26, and I think Hansard perhaps heard 21.

OK, we have an amendment that’s being placed by Ms Witmer.

Ms Smith: No, it’s our amendment, Mr Chair.

The Chair: This is an amendment to the amendment that we had previous knowledge of.

Ms Smith: Oh, sorry, Mr Chair. We don’t have a copy of it.

The Chair: No, it’s going to be circulated right now. As before, we’ll deal with the amendment to the amendment, and then the amendment itself.

Mrs Witmer: I move that clause 21.1(4) introduced by the government, this new amendment—I guess what we’re trying to do is keep on top of all these new amendments—be amended and the following clause substituted:

“The minister may refer the matter in dispute and any representations made under subsection (3) to the Lieutenant Governor in Council who, acting in the public interest, may issue a compliance directive.”

Again, this speaks to what we believe is the need for these agreements to at least have an airing at the cabinet table and that the minister not be allowed to continue, in a heavy-handed way, to unilaterally impose agreements on hospital boards. In fact, it goes contrary to what you have proclaimed in your press release, which is really misleading. You say here:

“The Ontario government tabled the following key amendments to clarify the intent of the bill: ...

“Stating that accountability agreements will be negotiated between boards and the minister.”

Folks, that is not the case. These are not the facts before us. You’ve stated that if they cannot reach an agreement after 60 days, it can be imposed unilaterally. I wish you had told the whole story in the news release.

Ms Martel: I appreciate what Ms Witmer is trying to do with this amendment, which is to check the power of the minister. The reason I can’t support it is that I don’t think it makes the situation much better if it’s cabinet that can review what the minister is doing. The minister is part of the government; I assume the cabinet is going to support one of their ministers, otherwise he or she wouldn’t be in that position.

So I’d make the argument again that if you are trying to do this in a manner that is not arbitrary and heavy-handed, then the best way to do that would be to have an independent party do that. I can’t support the amendment, because I continue to believe that there has to be an independent third party—Independent of both of the parties; that is, of government and of the boards—that will have the final say.

1430

Ms Smith: I would just remind the committee members and those listening at home that in fact the minister and the health resource provider shall negotiate the terms of an accountability agreement under this legislation under section 21, as amended, an amendment that we just passed, and it is only in those circumstances where an agreement cannot be reached that the minister may issue a directive. So unlike the member opposite, who continues to insist that they aren’t negotiated, we have made it quite clear that these agreements will be negotiated between the boards of hospitals and the ministry.

Ms Martel: I was not going to intervene, but I have to. I’m sorry, that’s just not the case. We’re sitting here, and I have asked very pointed questions about what happens if an agreement can’t be reached. In every case where an agreement can’t be reached, the minister can unilaterally impose a solution. That is not negotiation, by anybody’s standards.

I appreciate that the government would like the public to believe, and would like the hospital boards in particular to believe, that these are going to be negotiated. But when the minister has the final say, when the minister wields the big club, the big stick, and the minister decides what is going to be imposed, that’s not negotiation, that is arbitrary use of power. The government shouldn’t be going down that road, because the government is going to lose good volunteers who will not have any part of that and who will say, “I don’t want to be anywhere near this.”

If the government was smart and meant what it said, the government would find an independent third party to deal with these mechanisms instead of continuing to have language here that makes it clear that at the end of the day the minister, and the minister alone, has the final arbitrary say and the power to do what he or she wants to and impose.

Mr Klees: Ms Martel, that was very well said. I want to endorse everything that Ms Martel has said here. Somehow we’re not getting through to the members of the government. I’m not sure what Kool-Aid you people were fed for breakfast, but somewhere along the line you have to understand that for you to say and try to get anyone—even your own staff are embarrassed now at your performance on this. The minister has to be watching this by closed-circuit television, and he’s cringing. For you, on one hand, to argue that there is in fact arbitration but then to allow that when all that arbitration is done the minister still reserves the right to do whatever he wants to do—what planet are you folks on?

We have a letter here from one of the hospitals, signed by all the members of the board who effectively are

saying that if you do this, they will resign. The suggestion is that there are boards right across this province who will do the same. It's also been suggested that maybe that's what you want, that maybe what the Minister of Health wants, what this government wants, is a wholesale resignation of every volunteer member of every board in the hospital, for them to just pack it in so you can do whatever you want. Effectively, that's what you're leaving them with. I think you're going down a very, very dangerous path here.

Chair, I'm going to ask for a recorded vote on this, so that people right across the province will know which member of the government here continues to insist that there is not, and should not, be a meaningful role for volunteer board members. Folks, take note of who casts the vote here.

Mr Duguid: I think it's important to note, as we're speaking about this particular item, that in fact the board—as a member of a board of a hospital for nine years prior to being elected here, I can assure the members opposite that the boards will be able to deal with their duties just as they have in the past. But we will not do what the members opposite did: We're not going to drag our feet when it comes to reforming this health care system. We've got to move forward with these reforms, and the only way we're going to do that is by putting an effective form of accountability into this system.

My view is that the motions they've been moving have been foot-dragging motions that are just going to ensure that we never get on with the important reforms we have to make to this health care system. We're not apologetic about the fact that we're going to have some strong accountability in this bill; we need it if we're going to move this system from the state it's in now to an improved state that the people of Ontario, frankly, have elected us to do.

The Chair: I would remind everyone that we are speaking to an amendment that the minister may refer the matter in dispute to the Lieutenant Governor in Council.

Mr Bob Delaney (Mississauga West): I have only one brief remark. I'd like to thank Mr Klees for his passionate defence of Ms Martel, who has just spoken against his party's amendment.

Mr Klees: If I can speak to that, Ms Martel spoke very strongly in favour of ensuring that there is third party arbitration here. I support her wholeheartedly in that and will continue to do so.

My point was that this bill, contrary to Mr Duguid's assertion—and I'm surprised, as a former member of a board; this is what happens, Brad, when you move from the real world into this world of being told what to do as a member of the Liberal caucus. Somehow there's a disconnect with reality. I feel for you, because I know you're pain inside. You would like to do the right thing—I know that—particularly because you know how important the role of a board member is, the experience they bring to the table and that they don't need the kind of heavy-handedness that this bill is going to bring down on the board. So you would want to vote in favour of this, I know, if you had your own way, if you were free to do

so. I would say that we should accept this amendment. It doesn't go all the way, as Ms Martel indicated, but it is certainly a step in the right direction. There are other amendments that we have here that will take it the distance. So we're going to watch very carefully to see what Mr Duguid does.

Interjection.

Mr Klees: We wish you well. This is only the beginning. This is only your first bill. After your 20th or 30th bill, after you find out that you really have no say as a Liberal backbencher, I believe that you in particular, Mr Delaney, who I have a great deal of respect for as well, will at some point take a stand and say no to your minister and no to your leader, and say, "Let's really reform how we do business in this place. Let's do the right thing, because it's the right thing to do."

Mr Leal: Today I've witnessed the greatest conversion since Saul on the road to Damascus from my respected friends from the Conservative Party. These are the same people, through Bill 26 with their good friend Duncan Sinclair, who went around this province. They didn't give hospital boards in Ontario days to make decisions; they gave hospital boards hours to make decisions. It's really interesting. Winston Churchill once said you shouldn't try to rewrite history when some of the players are still around to verify the facts.

The Chair: Ms Wynne?

Ms Wynne: No.

The Chair: We had such a civil morning too, didn't we? Ms Witmer.

Mrs Witmer: I would just like to remind Mr Leal that, coming out of the health restructuring commission and Dr Sinclair, your community had the good fortune of getting a new hospital. So I don't think things worked out all that badly.

Mr Leal: That's not my point.

Mr Klees: Of course it's not your point.

Mr Leal: It was your pressuring with a gun for boards to make decisions. I'm not talking about the outcome; I'm talking about the process, Mrs Witmer, to get a decision made.

The Chair: Through the Chair, please.

Mr Leal: You know full well that Duncan Sinclair put the gun to boards' heads to make decisions within hours. That's a fact.

1440

Ms Martel: If I might, Mr Chair, since I've been referenced a couple of times here, let me make it clear that the amendment I would support would be one that would establish an independent arbitrator process, independent of cabinet and independent of the two parties. I won't be able to support the amendment put forward by the Conservatives, because it doesn't do that. It goes right back to the government and we're going to be in the same position.

Just with respect to what Mr Leal said: He's right that Bill 26 was obnoxious. But it was not obnoxious because of how many hours or minutes or days hospital boards were given to respond; it was obnoxious because of the

overwhelming, unnecessary, arbitrary power of the commission, fronted by the minister, to essentially determine how boards and hospitals were going to operate.

I just have to say as strongly as I can, why do you folks want to go down the same road? Why? You are, in this bill, maintaining arbitrary, unnecessary powers for the minister. Nobody who came before us disputed the need for accountability agreements; they said they had to be negotiated. You could get yourself out of this problem by ensuring, in those cases—as you have said, those rare cases—where the board and the minister don’t agree, that you have an independent process whereby the final decision is made, instead of the minister coming forward in a heavy-handed way and imposing something. I can’t stress enough to you how you are going down the same road that they did when they were in government by allowing the minister to have the final say and imposing something in an arbitrary manner.

Do yourselves a favour and find a process, for those rare occasions when people can’t agree, where something is done independent of both of the parties and a decision is made in the end by an arbitrator and the parties have to live with it. That’s a much better solution than having the minister impose something in your community.

The Chair: Mr Klees?

Mr Klees: I rest my case.

The Chair: We’re all feeling each other’s pain; I can tell. Quite the little amendment; you sparked the debate of the day, I think.

Mrs Witmer: Debate is healthy.

The Chair: It is. I’m going to ask that we vote on the amendment now.

Mr Klees: Just before we do, could you take the shackles off the members of the government?

Ayes

Klees, Witmer.

Nays

Delaney, Duguid, Leal, Matthews, Martel, Smith, Wynne.

The Chair: That amendment loses.

We return to the original amendment on page 48. Any further debate on that motion? Seeing none, all those in favour?

Ayes

Delaney, Duguid, Leal, Matthews, Smith, Wynne.

Nays

Klees, Martel, Witmer.

The Chair: We’re moving on to page 49.

Mrs Witmer: I move that the bill be amended by adding the following section:

“Trade unions and collective agreements

“21.1 Despite any other provision of this part,

“(a) no trade union shall be required to enter into an accountability agreement, or be the subject of a directive;

“(b) no collective agreement shall be the subject of an accountability agreement or of a directive or an order under this part;

“(c) no accountability agreement or directive or order under this part shall directly or indirectly affect the continued operation and enforceability of a collective agreement or interfere with the ability of the parties to a collective agreement to comply with its terms.”

Obviously we have heard from the deputants who came before this committee—members of unions, associations—concerns about the ability of the accountability agreements somehow at the end of the day to override their own collective agreements and cause changes in the terms of those agreements which could mean a loss of jobs or certainly changes in any one of the provisions.

The Chair: Are there any further speakers to this amendment? Seeing none, all those in favour? Oh, Ms Smith, I’m sorry.

Ms Smith: I just wanted to address the fact that section 19, as amended, clearly states that trade unions are not health resource providers. We made that perfectly clear.

The Chair: All those in favour? Those opposed? That motion is lost.

Moving on to page 50: Ms Witmer.

Mrs Witmer: I might ask the government, on this amendment, whether or not we’ve made changes that would speak to what is intended here. Has that been covered?

Ms Smith: I’m sorry; could you repeat the question?

Mrs Witmer: The amendment here is, “Despite any other provision of this act, the organizations known as family health networks, primary care networks and family health groups shall not be required to enter into accountability agreements.” I’ve suggested that the bill be amended by adding the following section, and then said “certain exceptions.”

Ms Smith: Section 19, health resource provider, is clear that the definition does not include physicians or practitioners as defined under the Health Insurance Act or groups of physicians or practitioners in his, her or its capacity as physician practitioners or groups that receive payments.

Mrs Witmer: In essence, that’s what these are. These are groups. So would 19 already cover those?

Mr Maisey: Yes, that’s right.

Ms Smith: My understanding is yes.

Mrs Witmer: If that’s the case, I would withdraw this motion.

The Chair: Section 22, page 51: Ms Smith.

Ms Smith: Mr Chair, we’ve provided the clerk with a copy of a change to this amendment. It’s a very small

change, and the revised amendment is being distributed right now.

The Chair: So this amendment replaces what we have before us in its entirety?

Ms Smith: Actually, we're missing page 3. The change appears on page 2. So if the members would kindly—

The Chair: Keep their page 3?

Ms Smith: Yes; 51 and 51(b) are replaced by the two pages we've just given you, and 51(c) remains intact.

Can I take the members through the amendment? Ms Witmer, are you OK?

Mrs Witmer: Yes, I've found it. Thanks.

Ms Smith: I move that section 22 of the bill be struck out and the following substituted:

“Compliance directives—health resource provider

“22(1) If any circumstance referred to in a notice under subsection 21.1(1) continues for more than 30 days after the notice was given by the minister, the minister may issue a compliance directive to the health resource provider.

“Compliance

“(2) The health resource provider shall comply with a compliance directive.

“Directions

“(3) A compliance directive may require the health resource provider to comply with any directions set out in the compliance directive relating to the following:

“1. Requiring the health resource provider to enter into an accountability agreement with the minister on the terms set out in the compliance directive.

“2. Requiring the health resource provider to enter into a performance agreement.

“3. Requiring the health resource provider to comply with a provision of this part, a term of an accountability agreement, or a term of a performance agreement.

“4. Requiring the health resource provider to meet with the minister or any person designated by the minister, at a time and place set out in the compliance directive, for the purposes of discussing any non-compliance identified by the minister.

“5. Requiring the health resource provider to carry out or cause to be carried out an audit, as directed by the minister.

“6. Requiring the health resource provider to study and to report to the minister on any matter as directed by the minister.

“7. Requiring the health resource provider to provide any information identified in the compliance directive to the minister or to otherwise assist the minister or any person authorized by the minister to conduct an audit or carry out a study or report in respect of the operations of the health resource provider.

“8. Requiring the health resource provider to develop or implement an education or remedial learning plan for the health resource provider, or to follow an educational or remedial learning plan.

“9. Requiring the development of a budget for the review and approval of the minister as set out in the compliance directive.

“10. Requiring compliance with a budget as set out in the compliance directive.

“11. Requiring the posting and distribution of any matter as required by subsection 29(3).

“12. Taking any action or refraining from taking any action that is specified in the compliance directive to correct the circumstance of non-compliance described in the notice under subsection 21.1(1), to prevent its reoccurrence, or to remedy any effects of the circumstance of non-compliance.

“Times

“(4) In any compliance directive, the minister may specify the time or times when or the period or periods of time within which the health resource provider must comply with the directive.

“Directions not in notice

“(5) Despite subsection 21.1(2), a compliance directive may set out a direction that the minister did not propose in the notice under subsection 21.1(1).

“Varying

“(6) The minister may vary a compliance directive after it is issued if the change relates to a circumstance referred to in the notice under subsection 21.1(1).”

1450

The Chair: Speaking to the motion?

Mrs Witmer: I take a look at this motion and I think it's pretty heavy-handed. We're talking now about compliance directives, and if the government is committed to, in the first place, having negotiated agreements, I'm not sure these are appropriate in that context. It again speaks to the fact that one party has the ability to unilaterally change the terms at any time, and therefore the original agreement doesn't seem to have much in the way of certainty or clarity or mutuality.

I would have to, in particular, vote against 22(3)1, which requires the health resource provider to enter into an accountability agreement with the minister on the terms set out in the compliance directive. As I said, the compliance directive should not be there if you've got a negotiated agreement. Everything should be done in good faith.

I look at number 5, where you require the health resource provider to carry out or cause to be carried out an audit as directed by the minister. I don't believe a compliance directive should contain a direction that was not contained in the original notice. For those stakeholders who are going to be impacted by this changed amendment, I'm not sure that it's not worse than what we had before, and I don't think it reflects in any way the comments we heard, certainly from those who had a lot of concern around the accountability section. So I would not be able to support this.

The Chair: Any further speakers?

Seeing none, all those in favour? Those opposed? That motion is carried.

We've got an official opposition motion, page 52.

Mrs Witmer: I guess we're trying to look at a process. We've tried to involve and do it in the way of an order in council. We've tried to introduce arbitration. I guess this is another attempt on our part to make sure that some third party takes a look.

I move that section 22 of the bill be struck out and the following substituted:

“Compliance provisions

“22(1) If any party to an accountability agreement believes that another party has failed to comply with the terms of the agreement, the party seeking compliance shall send a notice in writing setting out,

“(a) the nature of the alleged breach of the agreement; and

“(b) the remedy sought.

“Meeting

“(2) Within 30 days of the giving of a notice under subsection (1), or such other time agreed to by the parties, the parties shall meet to determine if they can reach agreement on the matter.

“Mediator

“(3) If the parties cannot reach an agreement within 30 days of their first meeting, or such other time agreed to by the parties, a mutually acceptable mediator shall receive submissions from the parties, consider the issues in dispute, and meet with the parties.

“If cannot agree on mediator

“(4) If the parties cannot agree on a mediator, each party shall submit a list of three mediators to a judge of the Ontario Supreme Court, who shall consider any submissions the parties make and choose a mediator.”

“Arbitrator

“(5) If the parties cannot reach agreement within 90 days from the appointment of the arbitrator, or such other time agreed to by the parties, a mutually acceptable arbitrator shall consider their submissions and decide the matter.

“If cannot agree on arbitrator

“(6) If the parties cannot agree on an arbitrator, each party shall submit a list of three mediators to a judge of the Ontario Supreme Court, who shall consider any submissions the parties make and choose an arbitrator.”

This really goes back to making sure that this accountability agreement has accountability going both ways and speaks to the inappropriateness of compliance directives being imposed on just those other than the minister.

The Chair: Any further speakers?

There being none, all those in favour? Those opposed? That motion is lost.

Shall section 22, as amended, carry?

Those in favour? Those opposed? That motion is carried.

I draw your attention to page 53, which is not a government motion, as listed, but a recommendation. There are no amendments. The question is, shall section 23 carry? Any debate? Is everybody clear?

All those in favour of the motion? All those opposed to the motion? That section is lost.

Moving on to section 24, we've got a recommendation. Just give me two seconds to consult with the clerk.

We're going to have a brief recess for about two or three minutes, if people need to refresh their coffee or drinks.

The committee recessed from 1459 to 1505.

The Chair: OK, ladies and gentleman, can we come to order again? I've consulted with the clerk. On section 24, with the committee's concurrence, the best way to deal with this and give justice to both issues—one obviously is a recommendation from the government that the vote should go against section 24, and the official opposition has moved “that section 24 be struck out and the following substituted”—I'm going to propose that we reverse the order and deal with the official opposition notice first.

Mrs Witmer: I move that section 24 of the bill be struck out and the following substituted:

“Renegotiation

“24(1) Any party to an accountability agreement may at any time request a renegotiation of all or part of accountability agreement or an order or agreement under this part if there has been a material change in the ability of the party to meet its obligations.

“Meeting

“(2) Within 30 days of the giving of a notice under subsection (1), or such other time agreed to by the parties, the parties shall meet to determine if they can reach agreement on the matter.

“Mediator

“(3) If the parties cannot reach an agreement within 30 days of their first meeting, or such other time agreed to by the parties, a mutually acceptable mediator shall receive submissions from the parties, consider the issues in dispute, and meet with the parties.

“If cannot agree on mediator

“(4) If the parties cannot agree on a mediator, each party shall submit a list of three mediators to a judge of the Ontario Supreme Court, who shall consider any submissions the parties make and choose a mediator.

“Arbitrator

“(5) If the parties cannot reach agreement within 90 days from the appointment of the arbitrator, or such other time agreed to by the parties, a mutually acceptable arbitrator shall consider their submissions and decide the matter.

“If cannot agree on arbitrator

“(6) If the parties cannot agree on an arbitrator, each party shall submit a list of three mediators to a judge of the Ontario Supreme Court, who shall consider any submissions the parties make and choose an arbitrator.”

Again, this refers to the ability that the legislation currently has to allow the minister to terminate an agreement or a directive or make a change. I guess we're suggesting again that negotiations take place.

We have heard how important it is to have stability within our health care system. It's absolutely essential that the health care providers can rely on the accountability agreements in place that they have negotiated with

the government. So we do not agree that, as stated in the government's bill, the minister should have the ability to terminate an agreement at any time. That certainly does not provide stability to the health care system.

As an example, let's take a look at SARS. During that time, the health system was faced with some challenges that were totally unforeseen and it did alter the course of events. Therefore, it's altogether reasonable to assume that health resource providers may possibly be confronted at some time with extraordinary circumstances that are going to severely impact their ability to fulfill their obligations under an accountability agreement. In order that we can provide for those situations, there has to be a provision not just for the minister terminating an agreement; there has to be a provision for renegotiating the agreement where there has been a material or significant change in the circumstances. This amendment would allow for that flexibility and would allow for both parties to have the opportunity, based on these unforeseen circumstances, to renegotiate an agreement. It doesn't give sole power to the minister to arbitrarily terminate an agreement.

The Chair: Are there any further speakers? It's unfortunate that Ms Martel isn't here, because I know she had a particular interest in this.

Mrs Witmer: She might like it.

The Chair: That's right. It's unfortunate.

Mr Klees: I think she would vote for it.

Mrs Witmer: Yes.

Mr Klees: Chair, I would like to suggest that you free up at least one of the government members who can vote the way Ms Martel would have voted on this.

Mrs Witmer: Brad?

The Chair: That would make them an official party if you moved.

Mr Duguid: I'm quite happy where I am, thank you.

The Chair: It could be expensive.

I was trying to stall a little bit in case Ms Martel came in, because I did want to offer her the opportunity to speak to this. I know she did have a particular interest.

Mr Klees, did you have any comments on this?

1510

Mr Klees: Perhaps while we're waiting we could get some explanation from the parliamentary assistant on the issue raised by Ms Witmer relating to the press release that leaves the impression with the public and the stakeholders that there is a negotiation that takes place and very clearly leaves out the fact that the final hammer is still there, giving the minister the ultimate and absolute authority to make the decision relating to this. We'd be very interested, first of all, why that was left out of the press release—although I think we know—and how the government can justify leaving a half-truth in the public domain.

The Chair: Are there any further speakers?

Ms Smith: I'd like to call the question.

The Chair: No further speakers?

Mr Klees: Is there a reason the parliamentary assistant isn't prepared to respond to that?

The Chair: Certainly it's her prerogative whether she responds or not.

Ms Smith: Exactly. The parliamentary assistant is not expected to respond to all your inquiries, Mr Klees, but thank you for them.

The Chair: I've just been advised by the clerk that if the question is called, it is not on the amendment; the question is actually on the section, so we would be voting on section 24, not on the amendment.

It would be my preference that we vote on the amendment.

Ms Smith: That's fine.

The Chair: I think everybody had exhausted their comments, in any event. We did extend some time in the hope that Ms Martel would join us. That appears to not be happening.

All those in favour of the amendment? Those opposed? That amendment is lost.

Moving on to the recommendation on section 24, any comments?

There being none, all those in favour? Those opposed? That motion is lost.

We are moving on to section 25 on page 56.

Ms Smith: I move that section 25 of the bill be struck out and the following substituted:

“Recognition of accomplishment

“25. If a health resource provider meets or exceeds all or part of the terms of an accountability agreement, the minister may, in his or her discretion, make an order directing that the accomplishment be recognized in any prescribed manner.”

The Chair: Speaking to the motion?

All those in favour? Those opposed? That motion is carried.

Moving on to page 57.

Mrs Witmer: I move that section 25 of the bill be struck out and the following substituted:

“Recognition of accomplishment

“25. If an agency or entity that is the subject of an accountability agreement meets or exceed all or part of the terms of the accountability agreement, the minister may, in his or her discretion, make an order directing that its accomplishment be recognized in any prescribed manner.”

The Chair: Are you speaking to the motion?

Mrs Witmer: Yes. Because the parties to an accountability agreement can only be the hospital corporation and the government, the word “person” should be deleted and, accordingly, the wording “his or her accomplishment” needs to be changed to “its accomplishment.”

Ms Smith: I believe those changes were accomplished through the previous amendment that we just passed.

Mrs Witmer: If the parliamentary assistant gives me the assurance that that's captured there, I would withdraw that motion.

Ms Smith: Yes.

The Chair: Thank you, Ms Witmer, I appreciate that. Shall section 25, as amended, carry?

Those in favour? Opposed? That motion is carried.

We are moving on to section 26, page 58.

Mr Kormos, the pages are all numbered at the top.

Mr Peter Kormos (Niagara Centre): Thank you kindly.

Ms Smith: Again, we have provided the members of the committee with a slight variation of pages 58 and 58(b). Do the members opposite all have that copy? It came during the coffee break, two pages.

Mrs Witmer: Yes, we do have it.

Ms Smith: You have it? OK, great. Ms Martel, are you OK with me reading through?

Ms Martel: Do you know what? I'm not sure. I'm sorry.

The Chair: It would be pages 58 (a) and (b) stapled together. I'm sure we can get you one quickly.

Ms Martel: Thank you. Sorry about that, Chair.

The Chair: No problem.

Ms Smith: Mr Chair, can I go ahead?

The Chair: You certainly can.

Ms Smith: I move that section 26 of the bill be struck out and the following substituted:

“Order—health resource provider

“26. (1) If the circumstance referred to in a notice under subsection 21.1(1) continues for more than 30 days after the notice was given by the minister, or if no notice was given by virtue of subsection 21.1(5), the minister may issue an order to the health resource provider.

“Compliance

“(2) The health resource provider shall comply with an order issued under subsection (1).

“Matters in order

“(3) An order issued under subsection (1) may require the health resource provider to comply with any directions set out in the order relating to any or all of the following:

“1. Requiring a health resource provider to comply with any part of a compliance directive that has been issued to the health resource provider.

“2. Requiring a health resource provider to comply with any direction that may be made in a compliance directive.

“3. Holding back, reducing or discontinuing any payment payable to or on behalf of a health resource provider by the crown in any manner and for any period of time as provided in the order and despite any provision in a contract to the contrary.

“4. Requiring a health resource provider to enforce any provision of a performance agreement with a chief executive officer.

“5. Varying any term of an agreement, as set out in the order between the crown and the health resource provider.

“Times for compliance

“(4) In an order under this section, the minister may specify the time or times when or the period or periods of time within which the health resource provider or chief executive officer must comply with the order.

“Direction not in notice

“(5) An order under this section may set out a direction that the minister did not propose in the notice under subsection 21.1(1).

“Varying

“(6) The minister may vary an order after it is issued if the changes relate to a circumstance which caused the order to be issued under subsection (1).

“Orders without notice

“(7) If, by virtue of subsection 21.1(5), the minister did not give notice under subsection 21.1(1) before issuing an order under this section, the minister shall, as soon as reasonably possible after issuing the order, provide the health resource provider with,

“(a) reasons for the issuance of the order;

“(b) the matters that the minister took into account in making his or her decision to issue an order; and

“(c) the matters that caused the minister to form his or her belief under subsection 21.1(5) and to not follow the procedures set out in subsections 21.1(1) to (4).”

The Chair: There is an amendment to the motion.

Ms Smith: I thought I saw Mrs Witmer moving while I was reading.

The Chair: That's right. The amendment will take precedence. We are now speaking to the amendment you have before you, moved by Mrs Witmer.

Mrs Witmer: I move that subsection 26(1), introduced by the government, be amended and the following subsection substituted:

“If the circumstance referred to in an order under subsection 21.1(1) continues for more than 30 days after the notice was given by the minister, or if no notice was given by virtue of subsection 21.1(5), the minister may refer the circumstance in writing to the Lieutenant Governor in Council who, acting in the public interest, may make an order dealing with the said circumstance.”

It's the power that is given in the original amendment of the government that we have a lot of concern with and that I know the stakeholders in the province are very concerned with. This is our attempt to at least allow for the Lieutenant Governor in Council to make the order, and to do so acting in the public interest, rather than allowing the minister to hold the hammer over the head of the health resource provider.

1520

The Chair: It was the amendments last time that sparked a lively debate. Are there any further comments?

Ms Martel: The same as before: I'm going to vote against it, with all due respect to my colleagues, because the Lieutenant Governor in Council is essentially the cabinet, and I don't see any difference between the cabinet and the minister in terms of what is being done. There should be an independent process to deal with these issues.

The Chair: Any further speakers?

Voting on the amendment, those in favour? Those opposed? That amendment is lost.

Returning to the main motion on page 58: Ms Smith, any further comments?

Ms Smith: No, Mr Chair.

The Chair: Any further speakers? No speakers?

All those in favour? Those opposed? That motion is carried.

Shall section 26, as amended, carry?

Those in favour? Those opposed? Section 26 is carried, as amended.

Moving on to—

Interjection.

The Chair: I'm sorry. I'm getting ahead of myself again. Mrs Witmer, I forgot to give you an opportunity to move and speak to the motion on page 59.

Mrs Witmer: In light of the fact that not one of our amendments has been given due consideration and passed by the government, and the fact that we've already now passed the new section 26 that the government has put in place, I will withdraw this amendment. The intent of our amendment here was that, "The minister shall continue to provide funding to a health resource provider at all times until an agreement is reached, or determined by an arbitrator"—in this case, there's not going to be one—"during the negotiation of, dispute over compliance with, or renegotiation of an accountability agreement." I just want some reassurance that the funding is going to be provided until, I guess, the heavy hammer comes down. Can someone give me that reassurance?

The Chair: It seems to be a reasonable question. Ms Smith, would you like to refer that to the appropriate person?

Ms Smith: I will try, Mr Chair. The appropriate people are sorting themselves out.

The Chair: I think the question is fairly straightforward. Mrs Witmer, do you just want to summarize the question perhaps?

Mrs Witmer: I simply want to know if the minister is going to continue to provide funding to a health resource provider until such time as an agreement is reached or, in this instance, since there's not going to be the due process we had hoped for, until a compliance directive is issued.

Mr Thomas O'Shaughnessy: The bill does not affect the ministry's funding of any provider of any services at all, as it's currently written. That's not the intent whatsoever.

Mrs Witmer: This whole section had to do with, and originally spoke to, the whole issue of the consequences of failure. I'm not sure that you've answered my question, and I'm not sure whether or not the government has the answers. I guess that is why I have a lot of unease with the process that we have embarked on today in regard to this part III, Accountability. It seems to me that these provisions have been somewhat hastily drafted. There's not been ample opportunity for those who are going to be impacted to take a look at what the real consequence of the changes to the amendments are. We certainly have not been able to take a look at what the consequences might be. It seems that even the ministry staff are not quite sure of the consequences. For that reason, I hope the government would bring these back for

further consultation with stakeholders after second reading of the bill.

Mr Klees: I'm interested in Mr O'Shaughnessy's comment that this bill is not intended to affect funding in any way, and yet I thought that we had just passed an amendment. Paragraph 26(3)3 refers to "holding back." It refers to an order that can be issued that "may require the health resource provider to comply with any directions set out in the order relating to any or all of the following," and then it talks about "holding back, reducing or discontinuing any payment payable to or on behalf of a health resource provider by the crown in any matter for any period of time as provided in the order and despite any provision in a contract to the contrary."

Mr O'Shaughnessy: If I could respond to Mrs Witmer's original question and perhaps clarify what I was trying to say: In response to Mrs Witmer's question, the bill doesn't affect any money currently funded under the existing arrangements that the ministry has with its partners, the organizations that provide services that the ministry funds currently.

Mrs Witmer: But we're talking about the new orders and the new accountability agreements. Are they going to have the power, as has been referred to here under 26(3)3, to hold back, reduce or discontinue?

Mr O'Shaughnessy: Certainly I don't want to comment on circumstances and a context that are not in front of me, or where we don't understand the circumstances that may be involved at the time. But yes, that's what the bill does say: Given the circumstances that may transpire at the time, there are powers or authorities in the bill which provide authority to vary or hold back certain funding based on exceptional circumstances. Of course, the intent of the bill is never to get to that point.

Mr Klees: So what you're saying is that, contrary to what you first said, this bill does provide for the discontinuation of existing funding?

Mr O'Shaughnessy: No, that's not what I said. You're skewing the words, Mr Klees. The bill does not affect funding or money paid to providers under existing arrangements. I'm not going to comment on the circumstances that might transpire once the bill is passed, or circumstances that may exist between a health resource provider and the ministry.

The Chair: The question has been asked and answered. I think we're maybe straying into the political realm with the staff. If you have a question that would be appropriately answered by a staff person, you've got Mr O'Shaughnessy there.

Ms Martel: It's the use of the word "existing." I'm wondering, then, is what you're talking about the funding that the minister announced for hospitals a couple of weeks ago? Is that that \$385 million or so that is the pot of money in question, to which this particular section would apply? I certainly have heard the minister say that hospitals have to sign accountability agreements before they get some of that money. Is that particular section, where we're talking about holding back, a reference to the new money that the minister announced a couple of weeks ago?

Mr O'Shaughnessy: It's in reference to existing funding arrangements. I know there are ongoing discussions and dialogue between the ministry and its hospital partners with respect to accountability agreements that will need to be signed for accessing the new money that was announced by the minister.

1530

Ms Martel: I don't want to put words in anybody's mouth, but I heard you tell Mr Klees that it didn't have anything to do with existing arrangements, and you just said it does have something to do with existing funding arrangements. I'm not trying to cause a problem here, but I really would like some clarification.

Mr O'Shaughnessy: I'm making a distinction between the existing arrangements and the funding that was just announced by the minister. There are ongoing discussions and dialogue with respect to that specific pot of money, that specific funding.

Ms Martel: Yes. And are the provisions of this bill applicable only to new money? I assume the accountability agreements are going to take into account everything that is done in a hospital, not just what might be done with the new money. Am I correct?

Mr O'Shaughnessy: No accountability agreements have been signed at this point, and I don't think I'm going to comment any further on that question.

Mrs Witmer: Well, I guess we do need an answer, because I think there's a lot of concern amongst the hospital community as to whether or not they are going to receive that \$385 million without signing the accountability agreements that are referred to in this legislation. If they are indeed going to be required to sign the accountability agreements we're talking about here, then somebody is really holding a big club over the heads of the hospitals, and I think it really was quite premature to indicate that this money would be forthcoming at a time when the government has not even passed this bill.

Ms Smith: If I could just clarify, I think we're on two different topics. We're talking about the funding that was announced two weeks ago and performance agreements that will be attached to that funding, which, as you've indicated, is premature; it's not "these" accountability agreements, because this legislation is not passed yet.

If it would please this committee, I will undertake to get a clarification on your original question with respect to section 26 and also clarification with respect to the new funding and the expectations around performance agreement signatures with that new funding. I'll try to provide that by the end of today. If we could move on to the next section, I think that might answer your concerns and allow us to move ahead.

The Chair: That's what I was going to suggest.

Ms Martel: Just on that, Mr Chair, can I get a clarification of the difference between performance agreements and accountability agreements as well?

The Chair: At the same time?

Ms Martel: Yes.

The Chair: True to form, we got stuck on an amendment that was going to be withdrawn.

Just to be clear now, shall section 26, as amended, carry? All those in favour?

Ms Smith: We've already passed it.

The Chair: It did already pass, but just to be clear, because we did go back on that amendment.

Those opposed? That section is carried.

Moving on to 26.1, page 60.

Ms Smith: I move that the bill be amended by adding the following section:

"Notice in exceptional circumstance

"26.1(1) The minister may give notice in writing to a chief executive officer and a health resource provider where:

"(a) the minister has issued a compliance directive or an order under subsection 26(1) to a health resource provider in respect of non-compliance by the health resource provider under the accountability agreement or any provision of this part or by its chief executive officer under a performance agreement or any provision of this part which the chief executive officer is required to comply with;

"(b) the minister believes that the health resource provider has not complied with an accountability agreement or any provision of this part or the chief executive officer has not complied with the performance agreement or has not complied with a provision under this part which the chief executive officer is required to comply with, despite a compliance directive or an order under subsection 26(1); and

"(c) the minister believes that, even though attempts have been made to require the health resource provider or chief executive officer to comply, an exceptional circumstance may exist which may require that an order be issued under subsection (5) to the chief executive officer and the health resource provider.

"Contents of notice

"(2) A notice under subsection (1) shall briefly describe,

"(a) the reasons for the notice; and

"(b) any directions that the minister proposes to recommend be made in an order under subsection (5)

"Dispute resolution process

"(3) After receiving a notice under subsection (1), where a chief executive officer or a health resource provider disputes any matter set out in the notice,

"(a) the minister and the health resource provider and the chief executive officer shall discuss the circumstances that resulted in the notice or any directions that are proposed in the notice;

"(b) the minister shall provide to the chief executive officer and the health resource provider any information that the minister believes is necessary to an understanding of the reasons for the notice or the directions that are recommended in the notice; and

"(c) the chief executive officer or the health resource provider may make representations to the minister about the matter set out in the notice.

"Consideration

“(4) The minister shall consider any representations made under subsection (3) before making a recommendation to issue an order under subsection (5).

“Order in exceptional circumstances

“(5) The Lieutenant Governor in Council may make an order to the chief executive officer and the health resource provider, where,

“(a) the Lieutenant Governor in Council believes that an exceptional circumstance exists which makes it necessary to issue an order;

“(b) a period of 30 days has passed since the minister gave notice under subsection (1) and the circumstance of non-compliance that caused the notice under subsection (1) to be issued has not been remedied to the satisfaction of the minister;

“(c) the minister has recommended in writing to the Lieutenant Governor in Council that the order be made; and

“(d) the minister has notified the chief executive officer and the health resource provider that he or she has made the recommendation to the Lieutenant Governor in Council and the reasons for the recommendation.

“Directions

“(6) An order issued under subsection (5) may require the chief executive officer and health resource provider to comply with any directions set out in the order relating to any or all of the following:

“1. Holding back, reducing or varying the compensation package provided to or on behalf of a chief executive officer in any manner and for any period of time as provided for in the order and despite any provision in a contract to the contrary.

“2. Requiring a chief executive officer to pay any amount of his or her compensation package to the crown or any person.

“3. Any prescribed matter.

“Compliance

“(7) A chief executive officer and a health service provider shall comply with the directions set out in the order.

“Times

“(8) In an order under subsection (5), the Lieutenant Governor in Council may specify the time or times when or the period or periods of time within which the chief executive officer and health service provider must comply with the order.

“Direction not in notice

“(9) An order under subsection (5) may set out a direction that the minister did not propose in the notice under subsection (1).

“Varying

“(10) The Lieutenant Governor in Council may vary an order after it is issued if the change relates to a circumstance which caused the order to be issued under subsection (5).

“Maximum limit

“(11) An order issued under subsection (5) shall not require the payment by the chief executive officer of more than, or shall not hold back, reduce or vary the

compensation package by more than, 10% of the compensation package in respect of the calendar year during which the non-compliance occurred which caused the notice under subsection (1) to be given.

“Prohibition

“(12) Where an order is issued under subsection (5) that holds back, reduces or varies the compensation package of a chief executive officer or requires the chief executive officer to make a payment,

“(a) no person shall provide any payment, compensation or benefit to the health resource provider or the chief executive officer or to any other person on behalf of the health resource provider or the chief executive officer to compensate for or reduce or alleviate the effects of the order on the chief executive officer, despite any provision at law or in a contract to the contrary; and

“(b) the health resource provider or the chief executive officer shall not accept or permit any other person to accept on its or his or her behalf any compensation, payment or benefit to compensate for or to reduce or alleviate the effects of the order on the chief executive officer, despite any provision at law or in a contract to the contrary.

“Civil enforcement

“(13) An order under subsection (5) that requires a chief executive officer to pay an amount may be filed by the minister with a local registrar of the Superior Court of Justice and enforced by the minister as if it were an order of that court.

“Same

“(14) Section 129 of the Courts of Justice Act applies in respect of an order filed with the Superior Court of Justice, and the date of filing shall be deemed to be the date of the order.”

Mr Chair, I misspoke under subsection 26.1(6). Might I reread subsection 26.1(6), or could we just delete paragraph 3 of subsection 26.1(6)?

The Chair: The clerk was suggesting we deal with the omission by an amendment.

Ms Smith: I’m in the clerk’s hands.

Mr Klees: I think we can just scrap the bill.

Ms Smith: Mr Chair, this has to do with the amendment that we spoke of this morning. It was the one amendment that we presented late. We were seeking to remove paragraph 3 of subsection 26.1(6).

The Chair: If you’d like to speak to that motion, in the interim we can see what we should do with paragraph 3, now that it has been read into the record.

1540

Ms Smith: OK. I think our amendments speak for themselves. We have had a number of discussions around this particular amendment, and we believe that there are all the safeguards in place that address the concerns raised by a number of stakeholders in our discussions with respect to this bill.

Mr John O’Toole (Durham): I was at committee this morning, the pre-budget hearings, but this afternoon I was in my office listening to these clause-by-clause discussions. The points that have been raised by Ms

Martel and Ms Witmer prompted me to come down here and be on the record.

This is really quite shocking from a non-political perspective. The current amendment that we're dealing with repeats the phrase that the ministry staff told us was not in the bill. That clarification, I know, has been the holdback provision. This goes further to make sure that the discounting of the CEO's or other health care provider's income to the extent of 10%—it's almost very difficult to accept; let's put it that way. They're providing in many cases—emergencies or whatever circumstances we find in our hospitals—yet they're going to spend all this time, effort and resources trying to comply with the ministry's direction. Also, I read in the last portion here, which is the civil enforcement portion, about allowing it to go to the Superior Court of Justice.

I just wanted to be on the record in saying I'm frightened by the draconian nature and statements within this bill. I met last week with the CUPE workers as well as a group of other health care providers, nurses and others, who are living in fear. You've unsettled the environment to the extent that other members from all caucuses—I'm sure from your own caucus—don't fully realize the state that you've created in the health care system today. I'm shocked.

I want to be on the record as strongly as possible in support of the hospital in my community. Their share of the \$358 million will not allow them to balance their budget. They know that now. We all know that 80% of their budget is wages and benefits. If they don't comply with the contractual arrangements that have been discussed with this new money, then clearly there will be court action.

I'm not sure the members on the government side really understand completely what this bill is doing. It's a comment only. I appreciate the Chair giving me the liberty to put my comments on behalf of my constituents in the riding of Durham.

Ms Martel: We heard repeatedly from hospital boards during the course of the public hearings who said that the CEO is their employee and it is their responsibility as board members to deal with issues arising with respect to the CEO—performance, salary, discipline if necessary etc. They made it absolutely clear on any number of occasions to the committee that they would see it as an intrusion—that's probably a polite term to use—by the minister if the government kept the powers that were in the bill unamended that essentially allow the minister to make a grab for compensation as a penalty for non-compliance. They made it very clear that it was their role to deal with those very serious and substantial issues and that they would do that if it was necessary and required of them.

The motion that we have before us today absolutely flies in the face of everything we heard from those volunteer boards about their concerns with respect to their CEOs. I say again, I do not understand what it's going to take for the government to understand the

impact the amendments are going to have on volunteer boards, which I think will not want to be party to anything like this and will just resign en masse.

Mrs Witmer: Despite the claims that have been made by the government as far as discussions with stakeholders regarding these amendments relating to these accountability agreements, I just want you to know that I understand, because we've certainly been hearing from people throughout the course of the day, that the health stakeholders are not happy with these amendments and they're not happy with this amendment, and I would concur with Ms Martel. We heard about the problem with the minister dealing with the chief executive officer. We heard about the need for there to be a single point of accountability, and that is the CEO to the board, not to the board and the ministry. You simply cannot have dual accountability, as is being suggested within this bill.

We know that the corporation is accountable for the corporate obligations. We know that it's the board of a hospital that holds its CEO accountable in order to ensure that the corporation honours its corporate obligations. We also know that boards are held to the highest fiduciary responsibilities and that they're required to act honestly and in good faith. This bill seems not to take into account that boards do take their fiscal obligations very seriously. They take into consideration the interests of the community they serve. You should also remember that a board can hold the CEO accountable for ensuring that corporate obligations are met.

These provisions are ones that we simply cannot support. I would again emphasize that because there has been such a large rewrite—in fact, I would say, a complete revamping of the entire part III, the accountability—I hope the government is prepared to allow this bill to go out again for further consultation after second reading. I'll tell you, nobody knows right now what the implications are of the changes that have been made, because we've got a real rewrite of the bill right here.

The Chair: Are there any further comments? Just to be clear—I've been conversing with the clerk—there are a few ways of dealing with this. One way would be to have Ms Smith read the entire motion, omitting (6)3. The other way of doing it, and which seems to me to be the most common sense way, would be for me to look everybody in the eye—and you understand that the motion is actually everything that Ms Smith read with the exception of 3, which is on page 60(c) in the centre of the page. The line that would be taken out would be, "Any prescribed matter."

Any member of the committee, just so everybody understands, has the right to ask Ms Smith to read the entire motion all over again.

Mr Klees: Chair, I am very tempted, but I will hold myself back.

The Chair: Just so that everybody understands, the motion on the floor is the motion that was moved by Ms Smith, with the exception of (6)3 on page 60(c).

Ms Martel: Recorded vote.

Ayes

Delaney, Duguid, Leal, Matthews, Smith, Wynne.

Nays

Klees, Martel, Witmer.

The Chair: The motion carries.

Section 27.

Ms Smith: I move that section 27 of the bill be struck out and the following substituted:

“Where change in employment

“27(1) Where, as the result of entering into a performance agreement under subsection 21(6) or the making of an order made under subsection 26(1) or 26.1(5), there is a material change in a chief executive officer’s terms of employment with a health resource provider, including a holdback, reduction or variation of the compensation package or a payment by the chief executive officer,

“(a) the change shall be deemed to have been mutually agreed upon by the chief executive officer and the health resource provider;

“(b) no proceeding shall be brought by or on behalf of the chief executive officer for any payment, compensation, benefits or damages from the health resource provider, the minister or any other person, despite any provision to the contrary at law or in his or her contract of employment, and

“(c) the chief executive officer shall not receive any payment, compensation, benefits or damages from the health resource provider, the minister or any other person, despite any provision to the contrary at law or in his or her contract of employment.

“Services

“(2) Subsection (1) applies with necessary modifications to a contract of agreement for services between a health resource provider and a chief executive officer.”

1550

The Chair: Speaking to this motion?

Ms Martel: Very briefly, this new section is as draconian as the provisions that appeared in the original bill, and I just can’t support this.

Mr O’Toole: Just to reiterate the strong language, specifically here, it says, “despite any provision to the contrary at law.” It overrides actual civil law, I gather, and it’s also stripping contracts here, the contract with the employer. That really is quite draconian.

Mrs Witmer: Again, as we’ve said before, it still gives a tremendous amount of power to the minister and only to the minister. The accountability throughout this section continues to go only one way, and for the hospital board or for the CEO, there’s absolutely no recourse. It’s interesting how in clause (a), “the change shall be deemed to have been mutually agreed upon by the chief executive officer and the health resource provider.” That is a joke. It’s the minister who has the power and not these other individuals.

Mr Klees: Further to Mrs Witmer’s reference to 27(a), for us to be entertaining legislation that would actually include this line is beyond me. I just can’t understand how you can justify that. You’re not only overtly saying that the minister will do whatever he or she chooses to do, but then you cover yourself off very nicely by legislation and say that regardless of what the minister has chosen to do, you’ll be deemed to have agreed to it.

Now I understand why the parliamentary assistant is so adamant in reassuring us all that this is going to be negotiated, because at the end of the day, regardless of how those negotiations go, the word will be that they agreed to it because they will have been deemed to agree to it.

This does not get any more archaic than anything I have ever seen. I can’t believe that Mr Bob Delaney—an upright individual who I understand was actually involved in helping to draft a lot of the policies of the Liberal Party coming into this last election, who I know is very disappointed at all those unkept promises of those good policies that he had a part in writing—now has to sit here and swallow this. A bitter pill it must be, particularly for Mr Delaney. I urge you to rise up, take a stand, let them know you’re not going to go down this road.

Chair, even you—I know that you don’t have a vote here and so you’re safe, but you’re shaking your—

The Chair: I knew you’d get around to me eventually.

Mr Klees: But you’re shaking your head as well.

In all seriousness, this is an insult to the men and women who serve us so well as CEOs and as members of boards of directors in hospitals right across the province. We just have to do what we can to express our frustration, our opposition to this. I would ask for a recorded vote when we vote on this to see whether or not some member of the government has the courage to vote against this.

The Chair: Any further speakers? Seeing none, a recorded vote has been called for.

Ayes

Delaney, Duguid, Leal, Matthews, Smith, Wynne.

Nays

Klees, Martel, Witmer.

The Chair: That motion is carried.

I’m going to call a very brief recess, for about two minutes, and allow Mr Leal to assume the chair for a period of time.

Mr Klees: We can’t take it. We’re so frustrated.

The Chair: You’re calling me names. I’m going to leave now.

The committee recessed from 1556 to 1605.

The Acting Chair (Mr Jeff Leal): We’ll bring the committee proceedings back to order. The next item we

deal with—I will ask if everybody has their paperwork there.

Shall section 27, as amended, carry?

Mr O'Toole: Recorded vote.

Ayes

Delaney, Duguid, Matthews, Smith, Wynne.

Nays

Klees, Martel, Witmer.

The Acting Chair: It's carried.

We'll now deal with section 28.

Ms Smith: I move that section 28 of the bill be struck out and the following substituted:

"Where change in funding, agreement etc

"28. Where, as the result of an order made under subsection 26(1), any funding or payment by the crown to a health resource provider is withheld, reduced or discontinued, or any term of a contract or agreement between the crown and a health resource provider is varied, the reduction, variance or discontinuance,

"(a) shall be deemed to have been mutually agreed upon by the parties; and

"(b) does not entitle the health resource provider to payment or compensation, despite any provision to the contrary at law or in a contract or agreement."

The Acting Chair: Discussion?

Mrs Witmer: Again, this is a tremendous insult in clause 28(a): "shall be deemed to have been mutually agreed upon by the parties" when "funding or payment by the crown to the health resource provider is withheld, reduced or discontinued, or any term of a contract or agreement between the crown and a health resource provider is varied." It's unbelievable that there's just no recourse. There's no accountability on the part of the minister at all. It really is an insult to that health resource provider.

Mr O'Toole: I appreciate being able to put a voice to the region of Durham and their concerns with this bill generally. Specifically, I do want to mention that Anne Wright, on behalf of Lakeridge Health Corp, serving Oshawa, Port Perry, Bowmanville and Whitby, did make a presentation to the committee and I did meet with them. I've reviewed their presentation. In fact, these very sections we're dealing with are where these amendments certainly don't do it. I appreciate the work of the volunteer boards, people like Anne Wright, across the province.

When "mutually agreed upon" is implied, this implication is sort of in a devious way, if that's an appropriate word, being able to do the press release and say: "Boards have agreed with the following conditions"—a 10% reduction of anybody that has a deficit, for instance. I can just see it.

I also want to put on the record, quite sincerely, and not hoping to upset anyone, that I'm quite disappointed

with the ministry staff person today in response. It almost had a political tone to it. I'm not accusing anyone. What I'm trying to say is, here again in this section it says very clearly that "payment by the crown to a health resource provider is withheld, reduced or discontinued, or any term of a contract...." The implication there is clear that they will hold back money if you don't provide certain outcomes.

I personally feel that the appropriate response from a non-political person would have been that that's a political question, because it is up to the minister. All of this is by the direction of the minister. Even the mutually agreed upon language that's been restated in the last three or four amendments I've been party to is language that is strange, to where it is circumventing the law. In fact, in the previous amendments we dealt with, it actually circumvents the law. "Contrary to any existing law," it says, I believe.

I'm wondering if Ms Wynne and others and you as well, Mr Leal, really appreciate what you've done for these community-based hospitals, volunteer boards, making decisions to provide services, in many cases at times of huge outbreaks or circumstances that are beyond their control. They can reduce the person's pay, it says, by 10%. It also says they can withhold payment or discontinue or, in fact, fine. In the sections further on, there are fines involved. I can't be supporting this bill, and I want to be clearly on the record in support of the health care providers in my community of Durham.

Ms Martel: Very briefly, here again with this amendment we see the huge contradiction with what the minister said publicly about this bill; that is, that these accountability agreements are going to be negotiated, which he reiterated even again this afternoon in a press release and upstairs in a press scrum that he had outside the Premier's office at 3 o'clock. You have him saying that these are going to be negotiated, and you have the actual text of the bill, the actual provisions, which are completely contrary to his statements—completely contrary.

Here we have another section where the minister can unilaterally make an order to reduce funding, change funding or discontinue funding per hospital agreements that the ministry has. That is completely unacceptable.

The provisions here are just as draconian as the provisions that the previous government had in Bill 26. The Liberals campaigned on a platform that they would be different, and I see no change.

1610

Mrs Witmer: I would just like to emphasize the fact that despite what the government has been saying about the consultations it's had with stakeholders in order to try to get this bill right, which started off with the wrong tone—and certainly a lot of sections have now been totally rewritten—this part III, the accountability section, still does not respond to the concerns that have been brought to our attention by the stakeholders, particularly the hospital association. I'm going to again ask the government to consider this bill going out for further

consultation after second reading. We are seeing here a total rewrite of part III. We've not been given adequate time to review these recommendations, nor have the stakeholders.

This is every bit as draconian and heavy-handed and unprecedented as anything that we have seen. It still gives all of the power to the minister. After 60 days, if there can't be an agreement negotiated, he or she has the power to force the health stakeholders to comply. I can tell you that this needs further study, and this is very, very unlike what the government said in the press release today. It says here, "accountability agreements will be negotiated between boards and the minister." That is not true. It's not accurate. Also, this press release starts out saying, "The McGuinty government took a major step forward in banning pay-your-way-to-the-front-of-the-line health care" as they took a look at this bill today.

Folks, we didn't do anything to do that. You didn't want to accept my recommendations to take a look at the issue of quality and accessibility and reducing waiting times. So that's totally misleading. This entire press release is misleading. You have not demonstrated your commitment to medicare in the amendments that you've brought forward.

The Acting Chair: Any further comment?

Ms Martel: Recorded vote.

Ayes

Delaney, Duguid, Matthews, Smith, Wynne.

Nays

Klees, Martel, Witmer.

The Acting Chair: It's carried.

Shall section 28, as amended, carry?

Ms Martel: Recorded vote.

Ayes

Delaney, Duguid, Matthews, Smith, Wynne.

Nays

Klees, Martel, Witmer.

The Acting Chair: Carried.

Now on to section 29.

Ms Wynne: I move that section 29 of the bill be struck out and the following substituted:

"Information

"29(1) For the purposes of carrying out the provisions of this part, the minister may require any health resource provider or chief executive officer to provide the minister with a performance agreement or any information that the minister considers necessary other than personal health information, in such form and at such times as the minister may require, and the health resource provider or

chief executive officer shall comply with the minister's requirement.

"Posting and distribution

"(2) A health resource provider shall post in a conspicuous place or distribute all or part of any accountability agreement, notice under subsection 21.1(1), compliance directive, order issued under section 26(1), notice under subsection 26.1(1) or order issued under subsection 26.1(5) when ordered to do so by the minister, even if this results in the disclosure of personal information.

"Public disclosure

"(3) The minister shall disclose to the public all or part of any accountability agreement, notice under subsection 21.1(1), representations under subsection 21.1(4), compliance directive, order issued under subsection 26(1), notice under subsection 26.1(1), representations under subsection 26.1(3), order issued under subsection 26.1(5) or any enforcement action taken by the minister even if personal information is contained in what is disclosed, if the minister is of the opinion that disclosure would promote accountability.

"Offence

"(4) Every person who fails to provide a performance agreement or information as provided in subsection (1) or refuses to post or distribute as required by subsection (2) is guilty of an offence and on conviction is liable to a fine of not more than \$10,000.

"Definition of 'personal health information'

"(5) In subsection (1),

"'personal health information' means information, other than information referred to in subsection (6), that is in oral or recorded form, if the information,

"(a) is information that identifies an individual or for which it is reasonably foreseeable in the circumstance that it could be utilized, either alone or with other information, to identify an individual, and

"(b) is information that,

"(i) relates to the physical or mental health of the individual, including information that consists of the medical history of the individual's family,

"(ii) relates to the providing of health care to the individual, including the identification of a person as a provider of health care to the individual,

"(iii) is a plan of service within the meaning of the Long-Term Care Act, 1994 for the individual,

"(iv) relates to payments or eligibility for health care in respect of the individual,

"(v) relates to the donation by the individual of any body part or bodily substance of the individual or is derived from the testing or examination of any such body part or bodily substance,

"(vi) is the individual's health number, or

"(vii) identifies an individual's substitute decision-maker.

"Exception

"(6) 'Personal health information' does not include identifying information contained in a record that is in the custody or under the control of a person if,

“(a) the identifying information contained in the record relates primarily to one or more employees or other agents of the person; and

“(b) the record is maintained primarily for a purpose other than the provision of health care or assistance in providing health care to the employees or other agents.”

Mr Chair, I just note that this amendment is designed to narrow the information-gathering provisions to health resource providers and CEOs only and to model the definition of “health information” on Bill 31’s definition.

The Acting Chair: Discussion on the government motion?

Mrs Witmer: We have another example here of a total rewrite of section 29 within this accountability section. We have no way of knowing whether or not this section does what it purports to do, and we have no way to ascertain what some of the consequences might be. There has been no opportunity for stakeholders in the province to take a look and review this. Again, I would just urge the government to send this bill back for further consultation.

Maybe Ms Martel did the right thing today. She thought the entire bill should be withdrawn. I can certainly tell you, the way we’re going about making changes to the bill has lead me to the conclusion that perhaps that’s what we should have done, because here’s another section that has been totally replaced. This bill not only had the wrong tone, it was really sloppily drafted.

The Acting Chair: Further discussion of the government motion?

All in favour of the government motion? Opposed? It is carried.

We now deal, Mrs Witmer, with your amendment.

Mrs Witmer: In light of the comprehensive rewrite, I guess this amendment no longer makes any sense, so we’ll have to withdraw it. How can we be responding to a bill when the government is rewriting every section? We can’t.

1620

Ms Wynne: I’d just like to make a comment that the whole purpose of the hearings that have been held on this bill has been to make changes to the bill. I understand that there may be a misunderstanding of what consultation is for, but that has been the purpose, and the extensive changes to the bill reflect the extensive hearings and the conversations with the stakeholders.

Mr O’Toole: That has precipitated a comment I would make myself. Ms Wynne has made the point, really. Consultations, it has been reported in my area, have been a sham, because the amendments we’re making here are in fact just tidying up some language issues and clearly leaving the control in the minister’s hands, and forced compliance. If they are of the view that this is consultation, then we’re in for a very difficult three or four years ahead. I feel badly for the volunteer boards and the health care providers, not just the victims of situations in hospitals where they’re dealing with contagious, infectious diseases etc. There’s no respect in this

bill. That’s ultimately what it comes down to: respect and working with the people who are trying to provide an essential service. And here we have the minister prepared to disclose information in the section we just voted on.

I agree with Mrs Witmer: The most immediate response I have is to continue the consultations. We all know that the 10% increase a year in health is just not sustainable. I think you would recognize it’s 50% of the budget, close to it, and we need to find better relationships and innovative responses to health care, and this bill clearly isn’t going that route at all. So I won’t be supporting it in any respect.

Mr Klees: I shouldn’t respond, but I’m forced to, to Ms Wynne’s comment about us not knowing about consultation. She may not know this, because she’s new to Queen’s Park, and in that sense I cut her some slack, but the fact of the matter is that the whole concept of doing committee consultations after first reading was something we introduced as a government. For Ms Wynne to suggest that somehow they are bringing this new concept of consultation to Ontario—there isn’t a stakeholder who has come before this committee who likes their definition of consultation. It’s one thing to listen to people; it’s another to hear them.

I’ll grant her that she has listened to many people over the last number of weeks, but they haven’t been heard. That’s our point, and that’s why we’re frustrated today. That’s why there are many others frustrated today, and that’s why there are some stakeholders who are, as Mr O’Toole said, afraid today.

At the end of the day, the Minister of Health does have the hammer. One of those hammers is the purse that feeds hospitals, that in fact feeds the fee schedule that is under negotiation now, and that feeds the expansion of hospitals right across the province that are at various stages of construction. What this government has not heard is that business cannot continue under the threat of this bill. This government is going down a path that they will regret.

Mr Duguid earlier made reference to the fact that we have to have accountability. That’s not being debated at all. We absolutely agree that there has to be accountability. But there also has to be a respect for contracts. There has to be a mutual respect for that accountability process. There has to be accountability on the part of the government as well to the good people in this province who are giving of themselves, whether it be through a professional career or through volunteer service to our communities. This government has not heard those stakeholders, and that’s why we’re sitting here with a pile of amendments, not one of which has been voted for by the government members—not one of them. We’re not suggesting we have all the answers but, surely to goodness, one or two amendments put forward by the opposition on behalf of stakeholders would have merited approval by the government. Not one.

So not only have they not heard stakeholders, they have not given any consideration to the work that’s been done by the opposition. It’s not a good day for the gov-

ernment of Ontario. I predict that Minister Smitherman will regret having moved forward with this bill and not taken our advice to retrench, go back to the drawing board and do what has to be done to ensure that there is co-operation with community hospitals and with our professional groups in this province to deliver health care efficiently and in an accountable manner. This bill is not going to do it.

Mr Duguid: The government members on this side are not going to sit here and be lectured about consultation by members of a government that frankly never knew the meaning of the word "consultation." We're talking about members of a government that imposed amalgamations without consultation on cities that didn't want them. We're talking about a government that imposed supervisors on hospitals, imposed supervisors on boards of education. We're talking about a government that frankly took very few bills out for consultation, like we have here.

This process has been a very valuable process. We've taken a lot of good ideas from all of the stakeholders throughout the province on this bill, and there are a lot of good ideas in the amendments that have come forward that go a long way to meeting the concerns that have been addressed.

But at the end of the day, we have to be responsible to the people of this province to move this health care system along and bring reform and changes. The previous government could not accomplish that. The people of this province have elected us to do that, and we will proceed. We will do it. We'll get this job done.

Mrs Witmer: I would just remind Mr Duguid that I think he's lost sight of the fact that those supervisors he talked about—that power was not totally in the hands of any minister. That was through an order in council. I would tell you that the power you've given the minister in this bill goes beyond anything we've ever seen in this province.

Do you know what? You were going to be the government that was different, decentralized. Well, that isn't what this bill is doing. You're centralizing power in the hands of a minister.

Mr Duguid: We're getting results is what we're doing.

Mrs Witmer: OK for you.

The Acting Chair: Further discussion?

Shall section 29, as amended, carry? All in favour? Opposed? It's carried.

Ms Smith: I move that section 30 of the bill be struck out and the following substituted:

"Non-liability

"30(1) No compensation or damages shall be payable by the crown, the minister or an employee or agent of the crown or minister for any act done in good faith in the execution or intended execution of a duty or authority under this part or the regulations, or for any alleged neglect or default in the execution in good faith of any such duty or authority."

"Same

"(2) No action or proceeding for damages or otherwise, other than an application for judicial review, shall be instituted against the crown, the minister or an employee or agent of the crown or minister for any act done in good faith in the execution or intended execution of a duty or authority under this part or the regulations or for any alleged neglect or default in the execution in good faith of any such duty or authority."

The Acting Chair: Discussion on the government motion?

All in favour of the government motion? Opposed? Carried.

Ms Witmer, please, your amendment.

Mrs Witmer: I think, again, we have an example here of an amendment being totally rewritten by the government, and so we have to withdraw this because there's nothing we can amend.

The Acting Chair: Shall section 30, as amended, carry?

All in favour? Opposed? Carried.

Ms Smith: I move that section 31 of the bill be struck out and the following substituted:

"Offence

"31(1) Subject to subsection (2), every health resource provider that fails to comply with an order under subsection 26(1), every health resource provider or chief executive officer who fails to comply with an order made under subsection 26.1(5), every person who fails to comply with subsection 26.1(12) and every person who wilfully attempts to circumvent or obstruct compliance with an order under subsection 26(1) or 26.1(5) is guilty of an offence.

"Exception

"(2) Despite subsection (1), where a health resource provider consists of a board of trustees of a non-profit oriented entity, an individual member of the board of trustees is not liable to a conviction for failing to comply with an order under subsection 26(1), if that individual receives no compensation of any kind for being a member of the board of trustees.

"Penalty—individual

"(3) An individual who is convicted of an offence under this section is liable to a fine of not more than \$10,000.

"Penalty—corporation

"(4) A corporation that is convicted of an offence under this section is liable to a fine of not more than \$25,000."

1630

The Acting Chair: Discussion on government motion 31?

Mr O'Toole: This is draconian, thoughtless provocation where people are going to be deemed guilty of an offence in groups and fined. It's just unconscionable, and the tone here is really more of substance than the bill itself. The tone of the bill is even worse.

The Acting Chair: Any additional discussion?

All in favour? Opposed? It's carried.

Section 31, as amended: All in favour? Opposed?
Carried.

Section 32.

Ms Wynne: I move that subsection 32(1) of the bill be struck out and the following substituted:

“Regulations

“(1) The Lieutenant Governor in Council may make regulations,

“(a) prescribing anything that may be prescribed for the purposes of this part;

“(b) respecting the content or terms and conditions of any accountability agreement;

“(c) prescribing manners in which accomplishment may be recognized in orders under section 25.”

The Acting Chair: Discussion on this government motion?

All in favour of the government motion? Opposed?
It's carried.

Ms Witmer, your motion?

Mrs Witmer: Thank you, Mr Leal. I move that section 32 of the bill be amended by adding the following subsection:

“Referral to Legislative Assembly

“(4) Every regulation made under this section shall be referred to the Legislative Assembly and reviewed by a committee of the Legislative Assembly.”

I guess we've heard throughout the course of the day that there's a tremendous amount of uncertainty and clarity regarding this bill and what it may and may not do. For example, we got into discussion about the \$385 million that's to flow to hospitals. We don't know if the intention is that that would be, I guess, captured within this bill before the money would flow. Certainly we've had ministry staff up here who haven't been quite sure what may or may not be in the regulation.

I think we want to make sure that the committee and the stakeholders have the opportunity to review the regulations, and before these regulations would become law—some of which we know already are going to be very heavy-handed and very draconian—that at least there would be an opportunity for some transparency and public.

The Acting Chair: Further discussion on Ms Witmer's motion?

Ms Smith: The government, in its amendment on page 71, will be introducing public consultation before making regulations, which I believe will address Ms Witmer's concerns.

Mrs Witmer: I've seen the government motion, the new motion, and it does not allow for the regulations to be reviewed by a committee of the Legislative Assembly. It only would go to cabinet. So there's a significant difference.

Ms Martel: That is the point I wish to make. I think the distinction between a regulation that's dealt with at cabinet every Wednesday and a legislative process with a legislative committee that is public and that is in Hansard should be clear on the record. There's a huge difference, and we need to acknowledge that.

The Acting Chair: Any more discussion?

All those in favour of Ms Witmer's motion? Opposed?
It's defeated.

Section 32, as amended: All in favour? Opposed? It's carried.

Section 32.1.

Ms Wynne: I move that the bill be amended by adding the following section:

“Public consultation before making regulations

“32.1(1) Subject to subsection (7), the Lieutenant Governor in Council shall not make any regulation under section 32 unless,

“(a) the minister has published a notice of the proposed regulation in the Ontario Gazette and given notice of the proposed regulation by all other means that the minister considers appropriate for the purpose of providing notice to the persons who may be affected by the proposed regulation;

“(b) the notice complies with the requirements of this section;

“(c) the time periods specified in the notice, during which persons may make comments, have expired;

“(d) the minister has considered whatever comments and submissions that members of the public have made on the proposed regulation, or an accurate synopsis of such comments; and

“(e) the minister has reported to the Lieutenant Governor in Council on what, if any, changes to the proposed regulation the minister considers appropriate.

“Contents of notice

“(2) The notice mentioned in clause (1)(a) shall contain,

“(a) a description of the proposed regulation and the text of it;

“(b) a statement of the time period during which a person may submit written comments on the proposed regulation to the minister and the manner in which and the address to which the comments must be submitted;

“(c) a description of any other methods by which a person may comment on the proposed regulation and the manner in which and the time period during which they may do so;

“(d) a statement of where and when members of the public may review written information about the proposed regulation;

“(e) any prescribed information; and

“(f) any other information that the minister considers appropriate.

“Time period for comments

“(3) The time period mentioned in clauses (2)(b) and (c) shall be at least 60 days after the minister gives the notice mentioned in clause (1)(a) unless the minister shortens the time period in accordance with subsection (4).

“Shorter time period for comments

“(4) The minister may shorten the time period if, in the minister's opinion,

“(a) the urgency of the situation requires it;

“(b) the proposed regulation clarifies the intent or operation of this part or the regulations; or

“(c) the proposed regulation is of a minor or technical nature.

“Discretion to make regulations

“(5) Upon receiving the minister’s report mentioned in clause (1)(e), the Lieutenant Governor in Council, without further notice under subsection (1), may make the proposed regulation with any changes that the Lieutenant Governor in Council considers appropriate, whether or not those changes are mentioned in the minister’s report.

“No public consultation

“(6) The minister may decide that subsections (1) to (5) should not apply to the power of the Lieutenant Governor in Council to make a regulation under section 32 if, in the minister’s opinion,

“(a) the urgency of the situation requires it;

“(b) the proposed regulation clarifies the intent or operation of this act or the regulations; or

“(c) the proposed regulation is of a minor or technical nature.

“Same

“(7) If the minister decides that subsections (1) to (5) should not apply to the power of the Lieutenant Governor in Council to make a regulation under section 32,

“(a) those subsections do not apply to the power of the Lieutenant Governor in Council to make the regulation; and

“(b) the minister shall give notice of the decision to the public as soon as is reasonably possible after making the decision.

“Contents of notice

“(8) The notice mentioned in clause (7)(b) shall include a statement of the minister’s reasons for making the decision and all other information that the minister considers appropriate.

“Publication of notice

“(9) The minister shall publish the notice mentioned in clause (7)(b) in the Ontario Gazette and give the notice by all other means that the minister considers appropriate.

“Temporary regulation

“(10) If the minister decides that subsections (1) to (5) should not apply to the power of the Lieutenant Governor in Council to make a regulation under section 32 because the minister is of the opinion that the urgency of the situation requires it, the regulation shall,

“(a) be identified as a temporary regulation in the text of the regulation; and

“(b) unless it is revoked before its expiry, expire at a time specified in the regulation, which shall not be after the second anniversary of the day on which the regulation comes into force.

“No review

“(11) No action, decision, failure to take action or failure to make a decision by the Lieutenant Governor in Council or the minister under this section shall be reviewed in any court.”

The Acting Chair: Ms Wynne, just a point of clarification on page 71: Could you repeat for us clause 32.1(1)(e), please, just for the record.

Ms Wynne: Clause (1)(e): “the minister has reported to the Lieutenant Governor in Council on what, if any, changes to the proposed regulation the minister considers appropriate.”

The Acting Chair: Discussion on new section 32.1?

Ms Martel: The government moved a similar motion at the end of part I of this bill with a similar provision regarding no review, and it seems to me that the minister had confidence in the regulation-making process and the decisions made through that process that that section wouldn’t be allowed. It gives the impression that they have something to hide or something to be concerned about with respect to the process itself, and I don’t think subsection 11 should appear in the bill at all.

1640

Mrs Witmer: Given the motion that we just introduced and that was defeated by the government, I’m looking for the committee to have an opportunity to view the regulations. We believe that is the appropriate course of action and that the consultation that is being proposed here simply doesn’t go far enough. The public really doesn’t have the opportunity to make sure the input they are giving is heard and considered in the rewrite of any regulations.

The Acting Chair: Any further discussion? Shall the government motion carry?

All in favour? Opposed? It’s carried.

Section 33.

Ms Smith: I move that subsection 15(3) of the Health Insurance Act, as set out in section 33 of the bill, be struck out.

The Acting Chair: Discussion?

All in favour? Opposed? It’s carried.

Continue, Ms Smith.

Ms Smith: I move that subsection 15.1(4) of the Health Insurance Act, as set out in section 33 of the bill, be struck out.

The Acting Chair: Discussion?

All in favour? Opposed? It’s carried.

Ms Smith, please.

Ms Smith: I move that subsection 15.1(6) of the Health Insurance Act, as set out in section 33 of the bill, be struck out and the following substituted:

“Interpretation

“(6) In this section,

“‘designated practitioner,’ ‘non-designated practitioner’ and ‘practitioner’ have the same meanings as in part II of the Commitment to the Future of Medicare Act, 2004.”

The Acting Chair: Discussion on that item?

All in favour? Opposed? It’s carried.

Shall section 33, as amended, carry?

All in favour? Opposed? It’s carried.

I’ll return the chair to Mr Flynn. I want to thank members of the committee for their co-operation during my time in the chair.

The Chair: Section 34: Any comments?

Seeing none, all those in favour? Opposed? Carried. Sections 35 through 39, there are no amendments. With the committee's concurrence, we could collapse those, unless there's anything that needs to be separated and spoken to.

Sections 35 through 39, collapsed: All those in favour? Opposed? Those motions are carried.

Moving on to section 40, we've got a government motion, page 75.

Ms Smith: I move that subsection 45(2.1) of the Health Insurance Act, as set out in subsection 40(3) of the bill, be struck out and the following substituted:

"Ministerial order

"(2.1) Upon the advice of the general manager, and where the minister considers it to be in the public interest to do so, the minister may make an order amending a schedule of fees or benefits that has been adopted in a regulation in any manner the minister considers appropriate for the purposes of the regulation."

The Chair: Speaking to the motion, Mr O'Toole.

Mr O'Toole: Just for clarification, would this be amending such schedules as the OHIP fee schedule or other clinic fees that are prescribed in regulation? What does this actually mean? Is it just a general ability to change any payment? There are fees allocated for procedural things, right from surgical procedures under OHIP fees to clinical diagnostic fees. They are all based on schedules, everything. Is this just in the hospital setting, or is it right across the board? Because under the Health Insurance Act—

Ms Smith: Perhaps we could ask for some technical advice on this, please.

The Chair: Who might be best to address this?

Ms Smith: Ms Montrose.

Ms Montrose: The provision allows for amendments to any schedule of fees or benefits prescribed under the Health Insurance Act. So that would be something like the schedule of benefits for physician services, dental services, chiropractic services, any of the insured services under the—

Mr O'Toole: Under the Regulated Health Professions Act.

Ms Montrose: No. I'm sorry?

Mr O'Toole: Fee'd services under the Regulated Health Professions Act.

Ms Montrose: Actually, they are only to the fee schedules prescribed under the Health Insurance Act, and that's for a limited range of practitioners: physicians, dentists, chiropractors, optometrists.

Mr O'Toole: I read in the media recently that there are ongoing negotiations with Dr Larry Erlick and Minister Smitherman on the OHIP fee schedule. They'll come to some agreement, hopefully without disruption of service by doctors. I think you're trying to avoid that. But this sounds to me like you'll be able to go in and render some of those fee schedules extraneous or not binding. Is that possible?

Ms Montrose: Right now the Health Insurance Act permits regulations to be enacted amending any fee schedule under that act. What this provision does is essentially allow amendments to be made without the necessity of going through the regulation-making process; for example, so that a fee schedule can be amended in the case of an emergency.

Mr O'Toole: I appreciate the debate here, because in health we spend so much money that we should know more about it. The pool under OHIP is a general amount. Generally the amount may not change, but would one of the provisions here be able to delist a service so that the fund doesn't change, that they could increase the fee for a hearing test but decrease any fee for eye tests?

Ms Montrose: That authority currently exists by regulation. This authority differs only in that it allows the minister in particular situations to amend the schedule without the necessity of moving through the regulations process.

Mr O'Toole: Very good; pretty strong powers.

Ms Martel: Just on the same point, can you give us an example of a circumstance where that would be necessary?

Ms Montrose: Perhaps a good example is what happened during the SARS epidemic. Generally speaking, services provided by telephone are not insured, and a number of physicians were incapable of rendering services in person and instead were rendering them by telephone. There was a significant period of time when it was unclear whether or not they'd be compensated for those services, because it would require a regulation which, as you know, takes some time to enact. This would allow, for example, the minister relatively quickly to cover that type of service so that everyone knows the service is insured when it's being rendered.

Ms Martel: I appreciate the nature of it, because I can see that as an emergency. I guess my concern is the flip side. What's the limit on the definition of "emergency"?

Ms Montrose: I just pulled up that example.

Ms Martel: It was a very good one, but as I'm listening to you and hearing about the discretion—that's a good example, and I would agree with that. I wonder, has the ministry been thinking about what the limitation would be? Doing it without regulation is a pretty broad power. At least with a regulation you have to come to cabinet.

Ms Montrose: There are certain limitations set out in the section.

Ms Martel: Could you point them out to me? My apologies; I'm not trying to put you on the spot.

Ms Montrose: If you look at (2.1), it must be in the public interest that the amendment be made, it has to be upon the advice of the general manager of OHIP and the orders made are time-limited.

Ms Martel: Where is the reference to "time-limited"?

Ms Montrose: In (2.2), the 12-month outside limit.

Ms Martel: That's a reference back to the original bill. OK.

Ms Montrose: That's right, and there's another provision further on which indicates that you can't use the

section to re-enact the same thing. So at the end of the 12-month period you can't say, "We'll continue this for another 12 months."

Ms Martel: All right. Thanks.

The Chair: Any further speakers?

Seeing none, all those in favour of the motion on page 75? Those opposed? That motion is carried.

Moving on to the motion on page 76: Ms Smith.

1650

Ms Smith: I move that paragraph 2 of subsection 45(2.2) of the Health Insurance Act, as set out in subsection 40(3) of the bill, be amended by adding "or benefits" after "fees" wherever it occurs.

The Chair: Any speakers?

Seeing none, all those in favour? All those opposed? That motion is carried as well.

Moving on to page 77: Ms Smith.

Ms Smith: I move that subsection 45(2.4) of the Health Insurance Act, as set out in subsection 40(3) of the bill, be amended by adding "or benefits" after "fees".

The Chair: Any speakers to that motion?

Seeing none, all those in favour? Those opposed? That motion is carried.

Shall section 40, as amended, carry?

Those in favour? Those opposed? Section 40 is carried.

Section 41: there are no amendments. Shall section 41 carry?

Those in favour? Those opposed? That is carried.

Moving on to the government motion on page 78: Ms Smith.

Ms Smith: I move that section 42 of the bill be struck out and the following substituted:

"Commencement

"42(1) Subjection to subsection (2), this act comes into force on royal assent.

"Same

"(2) Sections 1 to 6, 7 to 32, and 33 to 41 come into force on a day to be named by proclamation of the Lieutenant Governor."

The Chair: Any speakers to that motion?

Seeing none, all those in favour? Those opposed? That motion is carried.

Shall section 42, as amended, carry? Those opposed? Section 42, as amended, is carried.

Section 43 has no amendments. Shall section 43 carry?

Those in favour? Those opposed? Section 43 is carried.

Moving now to the preamble: Ms Witmer, on page 79.

Mrs Witmer: We're back to the preamble of the bill, and so far, as my colleague has noted, we've not had one of our amendments, which do reflect what we heard in committee, accepted by the government. We hope that in the preamble they will seriously consider some of the suggestions we've made. They do reflect input we've heard from stakeholders. I think it's important that the preamble reflect what's in the bill.

I move that paragraph 5 of the preamble to the bill be struck out.

We make this motion based on the fact that this is the section that references:

"Recognize that pharmacare for catastrophic drug costs and home care based on assessed need are important to the future of the health system;

"Recognize that access to primary health care is a cornerstone of an effective health system."

However, there is nothing within this bill that deals specifically in any way with pharmacare, with home care or with primary care, so we just wonder why we would include this in there. We recognize that those are all important components of the health system, as I know the government does, but the body of the bill certainly does not reflect this statement in the preamble. We don't see the connection between the preamble and the body of the bill, and that's the reason for our recommendation.

The Chair: Any further speakers?

Seeing none, all those in favour? Those opposed? That motion is lost.

Moving on to the government motion on paragraph 7.

Ms Smith: I move that paragraph 7 of the preamble to the bill be amended by adding "that reflects the public interest and" after "in a way".

The Chair: Paragraph 7 starts with "Affirm" or "Therefore"?

Ms Smith: Paragraph 7 starts, "Believe in public accountability."

The Chair: OK. Is everybody clear on the change in wording? Any speakers?

All those in favour? Those opposed? That is carried.

Going back to Ms Witmer, page 81.

Mrs Witmer: I'm glad that the last amendment was made. It does speak to the public interest, which of course is very important.

I move that the preamble to the bill be amended by adding the following paragraph after paragraph 7:

"Believe that the government and health resource providers must work collectively to ensure that the health system provides quality and timely care to patients."

We have talked about the fact that this bill supposedly commits itself to accessibility, to accountability. This amendment, I think, recognizes the shared responsibility that the government and the health resource providers have in order to ensure that if you're going to have accessibility, have improved access, you are going to have to ensure that Ontarians receive quality and timely care. Obviously, both parties have to be committed to ensuring that there is quality and timely care to patients.

I hope the government will seriously consider adding this to the preamble, which I think speaks to the need for co-operation between the government and the health resource providers. In fact, I'm not sure how the government could say no to this, if this bill is all about the commitment to medicare.

Mr O'Toole: In trying to find some reasonable respect here in tone, if not in substance, this small amendment to the preamble would put clearly before

people the commitment to timely and quality care. More importantly, it would at least indicate in some trivial way that you had listened to the opposition's voice in the debate.

If you're not going to adopt one single piece of advice from the former Minister of Health, Mrs Witmer, I think it's disrespectful. Maybe you're being whipped into voting every one of our amendments down. I understand that. But it might be just a token of respect. I think I'll deliberate as I watch the vote take place here.

The Chair: Any further speakers?

Seeing none, all those in favour? Those opposed? That motion loses.

Page 82: Ms Witmer.

Mrs Witmer: I move that the preamble to the bill be amended by adding the following paragraph after paragraph 7:

"Support negotiated accountability agreements between the government and health resource providers that enhance the accountability of both the government and health resource providers."

This amendment to the preamble, I believe, is an attempt to do what the government says they're doing, and that is to recognize that accountability is a shared responsibility and that it extends to everyone within the health system, whether it's the government or the health resource providers.

Also, we've talked about negotiated agreements. The government boldly proclaims today in its release that "accountability agreements will be negotiated between boards and the minister." If that is indeed your claim, I think then you would be in a position where you would want to support this because this will ensure that the role of the hospital board is not undermined. It's not going to have a negative impact on those who volunteer to serve on boards. If negotiated agreements are indeed the cornerstone of accountability in Bill 8, then no agreement can be valid unless it is entered into freely. I think it is very important to at least set out in the preamble that the objective is to reach negotiated settlements.

1700

The Chair: Further speakers?

Mr O'Toole: Out of respect for Mrs Witmer's work and consideration for a fair-minded approach here, I would ask for a recorded vote when this question is put.

The Chair: I'm afraid you can't ask for a recorded vote. Your colleague may be able to, but you can't.

Mr O'Toole: I understand. I'm just suggesting it.

Mrs Witmer: We'll have a recorded vote.

The Chair: I had a feeling we would. It was a technicality. Are there any further speakers?

Ayes

Martel, Witmer.

Nays

Leal, Matthews, McNeely, Smith, Wynne

The Chair: That motion loses.

Mrs Witmer.

Mrs Witmer: I move that the preamble to the bill be amended by adding the following paragraph after paragraph 7:

"Recognize the importance of ensuring and rewarding good governance of health resource providers."

I think that's what this bill is intended to do. It recognizes that these individuals are partners in accountability with the government, and obviously the government wants to do everything it can to promote good governance of the provider organizations. That's the intent.

The Chair: Any further speakers?

All those in favour? Those opposed? The motion loses.

We are moving on to page 84: Mrs Witmer.

Mrs Witmer: Thank you very much, Mr Leal—Mr Flynn.

Mr Leal: I made a lasting impression.

Mrs Witmer: You sure did. This is the only and last opportunity that the government has to even acknowledge that the opposition has a role to play. So far you have voted against every motion we've introduced. I would just remind you these motions are not figments of our imagination. I can give you the names, the presentations, the pages and the lines on the pages from the deputations that were made to us here in committee. They do reflect the input of those who were sincerely interested in making this bill better. I hope you will support this last one. It is to the preamble.

I move that the preamble to the bill be amended by adding the following paragraph after paragraph 7:

"Recognize that the promotion of health and the prevention of disease includes both mental and physical illness."

This is really important. You know, we talk about physical illness all the time. We have this poor second cousin of mental illness. Regrettably, I think the government has an obligation to try to effect a change and raise the stature of mental illness. This change to the preamble, I hope, will reflect the changing attitude of this government. It will reflect a better understanding of mental illness.

When I was Minister of Health, one of the things that I started to do was reform the mental health system. We still have a long way to go, and I hope your government will continue. But I can tell you that the mental health providers who appeared before us have asked for this amendment. I believe it is absolutely critical, I believe it is absolutely essential, if we really want to demonstrate that we're listening to those who deal with mental illness, that we would recognize that mental health services are an explicit and integral part of the health care system. We need to acknowledge those people who work so hard in the area of mental health services. I would encourage you to add this to the preamble.

The Chair: Any further speakers?

Mrs Witmer: Recorded vote.

Ayes

Martel, Witmer.

Nays

Leal, Matthews, McNeely, Smith, Wynne.

The Chair: The motion is lost.

We'll move on to page 85: Ms Smith.

Ms Smith: I move that paragraph 8 of the preamble to the bill be struck out and the following substituted:

"Affirm that a strong health system depends on collaboration between the community, consumers, health service providers and governments, and a common vision of shared responsibility;"

The Chair: Speaking to the motion?

Ms Martel: I wonder if the government would consider a suggestion. The word "consumer" appears elsewhere in the preamble too; I really despise the use of the word "consumer" when it comes to health care. I think we're talking about patients. It would be great if we could just change "consumer" to "patient."

Ms Smith: Ms Martel, I've raised this question, because it was raised at the committee hearings, and the reason we can't use "patients" is because the accountability agreement provisions also apply to long-term-care facilities where the residents are involved and are not considered to be patients. We could change it to "individuals."

Ms Martel: I'd be happier with that. "Consumer" is like, "Pay for your health care." This is just giving me absolutely the wrong sense of where we should be heading.

The Chair: Did I hear some agreement there, Ms Martel, that you would—

Mr O'Toole: The staff is giving us direction. The ministry staff are going to tell them what to do.

Ms Smith: Thank you, Mr O'Toole, for that insight. Ms Martel, if you'd like to introduce a friendly amendment to include "individual" as opposed to "consumer," we're open to that.

Ms Martel: I wasn't going to introduce amendments today. I made a conscious decision not to. Since we can't go with "patients," which is my first preference—let me get that on the record—then I would move that the friendly amendment be, "Affirm that a strong health system depends on collaboration between the community, individuals, health service providers and governments, and a common vision of shared responsibility;"

The Chair: Just hang on one second.

Ms Martel: While we're talking about this, the other problem is that "consumer" appears above, in the paragraph that starts with "Believe in a consumer-centred health system." I don't like that either, but trying to put "individual" in there doesn't work. If we have two different words, that's fine with me. But if we could find an even better word in that regard, I would be happier.

The Chair: Let's deal with this one first. Unfortunately it needs to be in writing, and it will be treated as an amendment to an amendment and can be dealt with quickly. We'd replace the word "consumers" with "individuals."

The amendment is that the word "consumers" will be replaced by the word "individuals." Speaking to that motion?

Apparently we need to get that photocopied.

Ms Smith: Can we move to the final motion on page 86 and come back to this, if we have unanimous consent?

The Chair: Agreed. We're going to move ahead to 86 and come back to 85 to deal with the amendment once it's been photocopied.

Mr O'Toole: Go ahead.

The Chair: Mrs Witmer, do you agree with changing the order of 85 and 86?

Mrs Witmer: That's fine.

1710

The Chair: We're just doing some photocopying for 85. So let's move ahead with 86.

Ms Smith: I move that the preamble to the bill be amended by adding the following paragraph after "high-quality health services to all Ontarians":

"Recognize the importance of an Ontario Health Quality Council that would report to the people of Ontario on the performance of their health system to support continuous quality improvement;"

The Chair: Anybody speaking to the motion?

Mr O'Toole: This may be late in the game, but is there any reference here to the role of the district health councils? Is there anything at all? The district health councils are supposed to be the planning arm for the ministry—non-partisan, whatever. But what is the health council going to be doing: working with them, for them? What are we doing here: creating another kind of governance model? That's regional health, that's what that is. This is a move toward regionalized health.

Mrs Witmer: That's it. That will be the next bill.

Mr O'Toole: It's clear. I can see it. It's coming. It's all a kind of chess game thing here.

The Chair: Are there any further speakers?

Ms Martel: I feel like I'm on a roll, so let me just get in my—you've heard this before and you're going to hear it again. I think this council should be able to make recommendations, so I would ask for a friendly amendment that would say, "would report to and make recommendations to the people of Ontario on the performance" etc.

The Chair: Actually, there is no such thing as a friendly amendment. We're inventing terms. It's either an amendment or it's not. Whether it's friendly or not is just really how you feel about it.

Ms Martel, if you are going to submit an amendment, it does need to be in writing.

Ms Martel: Just give me some word now. If it's going to be voted down, I won't even take the time. It's going to be voted down? OK, never mind. Forget it.

The Chair: Thank you.

We're still dealing with the motion on page 86. Are there any further speakers?

Seeing none, all those in favour? Those opposed? That motion is carried.

That's great timing. We've got photocopies of this major change. Ms Martel, this is your amendment. Would you like to read it into the record?

Ms Martel: I'll do the best I can, Chair.

I move that the amendment to paragraph 8 of the preamble to the bill moved by Ms Smith be amended by striking out "consumers" and substituting "individuals".

The Chair: Are there any speakers to that amendment?

Seeing none, all those in favour? That looks unanimous to me. We need to record that one.

Mr Duguid: Recorded vote.

Ayes

Duguid, Leal, Martel, Matthews, McNeely, Smith, Wynne.

Nays

Witmer.

The Chair: Now, if we can deal with the amendment on page 85, as amended: All those in favour? Those opposed? That motion is carried.

Shall the preamble, as amended, carry?

Those in favour? Those opposed? That is carried.

Should the long title carry?

Those in favour? Those opposed? That carries.

Shall Bill 8, as amended, carry? Any comments? Any debate? It's all been said?

All those in favour? Those opposed? That motion is carried.

Shall I report the bill, as amended, to the House?

Those in favour? Those opposed? It's carried. I shall report the bill.

That, ladies and gentlemen, I believe is the end of our proceedings.

Ms Smith: Mr Chair, I had promised clarification to the other side with respect to paragraph 26(3)(3). In fact, what section 26 does provide is for the issuance of an order that would hold back, reduce or discontinue "any payment payable to or on behalf of a resource provider by the crown." So, in fact, there is a provision to hold back or reduce a payment, which would be similar to the funding agreements that are now in place that allow the minister to hold back in long-term-care facilities when there is a breach of a service agreement. Hopefully that clarifies the confusion around paragraph 26(3)(3).

There is a 30-day notice provision, so that before such an order can be issued the non-compliance would be notified 30 days in advance and time to comply would be given. It's only in the case where there's a breach of an accountability agreement.

With respect to the \$385 million that was announced last week, \$50 million of that has been committed to nursing, and it is expected that the health service providers will make a commitment to provide that amount to nursing. The joint policy and planning committee, which is made up of the OHA and the ministry representatives, are working on future agreements which will be consistent with the accountability agreements that are set forward in Bill 8. I believe that addresses that concern or clarifies it.

Mrs Witmer: Thank you, Ms Smith. So in essence then, the money that has been committed, the total \$385 million, I guess you're saying, will only flow to the hospitals once the accountability agreements that we're talking about in this bill have been signed?

Ms Smith: No. To clarify that, the health service providers will be required to sign a sign-back letter agreeing that they will enter into negotiations on an accountability agreement when this legislation is in place. Those sign-back letters are being drafted as we speak. It is expected that that money will flow much sooner than prior to this legislation being passed.

Mrs Witmer: What are they committing to, then?

Ms Smith: To entering into negotiations for future accountability agreements.

Mrs Witmer: So basically they're signing their lives away, because if after 60 days there's no agreement on the agreement, then the agreement can be imposed by the minister.

Ms Smith: Again, Ms Witmer, we will continue to agree to disagree on this point. There is a provision that allows for the negotiation of accountability agreements. They will be able to enter into those negotiations with the ministry.

I also just wanted to address the concern you raised a couple times about whether or not this bill was going to be brought back to committee. I understand that issue is before the House leaders and in negotiation with the House leaders, and we expect some advice on that in the near future.

Mrs Witmer: Mr Flynn, I guess I do believe it inappropriate that the government has made a funding commitment that really depends on the passage of this bill. I think it's been quite presumptuous of the minister to be making that type of commitment. I think he is more or less shrugging his shoulders at the role of government and assuming the bill is going to be passed. I think he's taking a lot for granted.

Ms Martel: I have two requests, Chair. I'm not sure that I heard the difference between performance agreements and accountability agreements. Could I get that? I wonder if the parliamentary assistant would mind ensuring that the response that was given could be put in writing for the committee members. I would appreciate that.

Ms Smith: I will undertake to provide it in writing.

Just as a point of clarification on your question: Performance agreements are between the CEOs, and the boards as outlined in the bill, and accountability

agreements are between the boards of health service providers and the ministry. That's the difference there.

With respect to Ms Witmer's comments, I would just note that the JPPC has been meeting for an extended period of time already on some form of agreement, whether we call them service agreements, performance agreements or accountability agreements. It is expected that those negotiations will roll into what will develop as accountability agreements under this legislation. So I don't believe the minister has been presumptuous in any way. In fact, there have been ongoing negotiations to come up with these types of agreements, however we call them, moving forward.

Mrs Witmer: That having been said, I think it would have been courteous of the ministry to have informed the

JPPC, because I know they wondered what had happened to the negotiations that they were part of. Nobody has explained to them—I guess now we have an explanation and so now all of the stakeholders know where we're going. I would hope in future that we wouldn't have to raise this type of issue here and the stakeholders would have been informed as to what was going on and how those negotiations and discussions were going to be rolled into what's intended within this bill.

The Chair: Thank you very much. For many of us, this was our first time around, and for the more experienced people, thank you for your assistance. Thank you for your attention and your civility. We are adjourned.

The committee adjourned at 1722.

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STANDING COMMITTEE ON JUSTICE AND SOCIAL POLICY

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Mrs Elizabeth Witmer (Kitchener-Waterloo PC)

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Ms Susan Sourial

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of Ontario**

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**Official Report
of Debates
(Hansard)**

Monday 3 May 2004

**Standing committee on
justice and social policy**

Organization

Commitment to the Future
of Medicare Act, 2004

Chair: Jim Brownell
Clerk: Susan Sourial

**Assemblée législative
de l'Ontario**

Première session, 38^e législature

**Journal
des débats
(Hansard)**

Lundi 3 mai 2004

**Comité permanent de la
justice et des affaires sociales**

Organisation

Loi de 2004 sur l'engagement
d'assurer l'avenir
de l'assurance-santé

Président : Jim Brownell
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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON
JUSTICE AND SOCIAL POLICY

Monday 3 May 2004

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

COMITÉ PERMANENT DE LA JUSTICE
ET DES AFFAIRES SOCIALES

Lundi 3 mai 2004

The committee met at 1552 in committee room 1.

ELECTION OF CHAIR

Clerk of the Committee (Ms Susan Sourial): I call this meeting to order. Honourable members, it is my duty to call upon you to elect a Chair. Are there any nominations?

Mr Kim Craitor (Niagara Falls): I'm pleased to put forward the name of Jim Brownell as Chair of this committee.

Mr Ted Arnott (Waterloo-Wellington): I'd be happy to second that nomination.

Clerk of the Committee: Are there any further nominations? Seeing none, I declare nominations closed and Mr Brownell elected Chair.

The Chair (Mr Jim Brownell): Thank you, ladies and gentleman, for the confidence in my position as Chair. I look forward to working with you.

ELECTION OF VICE-CHAIR

The Chair: It is now my duty to call upon you to elect a Vice-Chair.

Mr Craitor: I'm pleased to put forward the name of Jeff Leal as Vice-Chair of this committee.

Mrs Elizabeth Witmer (Kitchener-Waterloo): I know we don't have to but I'll second that.

The Chair: There being no further nominations—oh, are there further nominations? I should ask that first, I suppose. There being no further nominations, I declare the nominations closed. Mr Leal, I welcome you. You are elected Vice-Chair of this standing committee.

SUBCOMMITTEE APPOINTMENT

The Chair: Next on the agenda we have the subcommittee on committee business. Do we have that?

Mr Craitor: Yes. I'm on a roll, so I'm pleased to ask that Mr Duguid be appointed in the place of Mr Gravelle on this committee.

The Chair: OK, we have Mr Duguid as a replacement on the committee. Any discussion? Any comments on the appointment to the committee? If not, I welcome you to the committee, Mr Duguid. Carried.

SUBCOMMITTEE REPORT

The Chair: Next we have the report of the subcommittee.

Ms Kathleen O. Wynne (Don Valley West): I'll read the report of the subcommittee.

Your subcommittee on committee business met on Tuesday, April 20, 2004, and recommends the following with respect to Bill 8, An Act to establish the Ontario Health Quality Council, to enact new legislation concerning health service accessibility and repeal the Health Care Accessibility Act, to provide for accountability in the health service sector, and to amend the Health Insurance Act.

(1) That the committee meet for the purpose of holding public hearings in Toronto on May 3, 4, 10 and 11, 2004, from 4 pm to 6 pm;

(2) That the committee invite the minister, if he wishes to appear, on Monday, May 3, 2004, for a 10-minute briefing statement followed by 10-minute statements by the official opposition and the third party;

(3) That the committee clerk, with the authority of the Chair, post information regarding the hearings on the Ontario parliamentary channel and the committee's Web site;

(4) That interested groups and individuals who wish to be considered to make an oral presentation on Bill 8 should contact the committee clerk by 5 pm, Wednesday, April 28, 2004;

(5) That if all groups can be scheduled, the committee clerk, in consultation with the Chair, be authorized to schedule all interested parties;

(6) That if demand exceeds availability, groups and individuals be chosen on a first-come, first-served basis;

(7) That late requests be accommodated if availability exceeds demand;

(8) That groups be offered 15 minutes in which to make a presentation and individuals 10 minutes;

(9) That the deadline for written submissions be 12 o'clock noon, Friday, May 7, 2004;

(10) That the research officer prepare an interim summary and a full summary of the testimony heard;

(11) That amendments be filed with the clerk of the committee by 12 noon, Thursday, May 13, 2004;

(12) That the committee meet on May 17, 18 and, if required, May 31, 2004, for clause-by-clause consideration;

(13) That there be no opening statements at clause-by-clause consideration; and

(14) That the clerk of the committee, in consultation with the Chair, be authorized, prior to the passage of the report of the subcommittee, to commence making any preliminary arrangements necessary to facilitate the committee's proceedings.

The Chair: You've heard the summary of the decisions made at the subcommittee on committee business. Are there any comments or questions? Seeing none, I would like to ask, all in favour of the report? Carried.

COMMITMENT TO THE FUTURE OF MEDICARE ACT, 2004

LOI DE 2004 SUR L'ENGAGEMENT D'ASSURER L'AVENIR DE L'ASSURANCE-SANTÉ

Consideration of Bill 8, An Act to establish the Ontario Health Quality Council, to enact new legislation concerning health service accessibility and repeal the Health Care Accessibility Act, to provide for accountability in the health service sector, and to amend the Health Insurance Act / Projet de loi 8, Loi créant le Conseil ontarien de la qualité des services de santé, édictant une nouvelle loi relative à l'accessibilité aux services de santé et abrogeant la Loi sur l'accessibilité aux services de santé, prévoyant l'imputabilité du secteur des services de santé et modifiant la Loi sur l'assurance-santé.

STATEMENT BY THE MINISTER AND RESPONSES

The Chair: We have with us this afternoon, and I would like to welcome, the Honourable George Smitherman, Minister of Health and Long-Term Care, to our hearings. Mr Smitherman will have 10 minutes to make a presentation, followed by the official opposition having 10 minutes, and then the third party will have 10 minutes. Welcome, Mr Minister.

Hon George Smitherman (Minister of Health and Long-Term Care): Thank you. I feel welcome.

I've got George Zegarac, I think well-known to you now, as assistant deputy minister.

It's a privilege to have another opportunity to address the committee on Bill 8, the Commitment to the Future of Medicare Act.

Since February, our government has heard from a cross-section of Ontarians and stakeholders as the committee travelled the province during the first public hearings. The bill has been the subject of spirited debate in the Legislature and in the media. And ministry staff have had the opportunity to meet one on one with groups about amendments that we introduced after first reading.

We've listened to Ontarians and we've made amendments that ensure Bill 8 is clear and true to its purpose: to

make our public medicare system responsive, accessible and accountable. This open and transparent dialogue has resulted in a bill that our government is extremely proud of.

I want to acknowledge and personally thank my legislative colleagues on the standing committee on justice and social policy from all parties. I'd like to recognize the past committee Chair, Kevin Flynn, Vice-Chair Jim Brownell and my parliamentary assistant, Monique Smith, for their leadership. I'd also like to congratulate Mr Brownell, who was elected committee Chair, and Jeff Leal, who assumed the role of Vice-Chair today. You're moving up.

I also want to thank all people who took an interest in this crucial bill and took the time to offer their perspective and their constructive criticism.

Bill 8 reflects the values of our government and the values that give medicare its life and meaning. I've said on many occasions that medicare is the very best expression of Canadian values. Our government believes in a universal, publicly funded health care system that gives us the care we need, on the basis of need, not on the size of our bank balance or on the quality of our Rolodex.

1600

Medicare does need our protection. There are various forces alive and well in Canada that claim that the only way to fix public health care is to abandon its principles and to offer a parallel private system for those who have money. Our government disagrees entirely. In Canada, health care is not a commodity to be bought or sold; it is a basic right. Are changes needed? Absolutely, but the changes we are talking about will bring our public system back to its founding values. These changes will breathe new life into medicare. Real, significant, system-wide change is needed to make medicare more responsive, more focused on quality outcomes and more accountable to the 12 million Ontarians who own the health care system.

No one has made the case for medicare renewal as passionately and as persuasively as Roy Romanow. He laid out the challenge ahead this way: "Canada's journey to nationhood has been a gradual, evolutionary process, a triumph of compassion, collaboration and accommodation, and the result of many steps both simple and bold.... That next step is to build on this proud legacy and transform medicare into a system that is more responsive, comprehensive and accountable to all Canadians." Bill 8 gives us an effective tool to change the status quo in Ontario.

The purpose of this landmark Bill 8 is to protect the defining values of medicare and to modernize and sustain medicare for future generations of Ontarians. During the debate about Bill 8, we heard a lot of what Bill 8 isn't. Today I want to celebrate what Bill 8 is and how it paves the way for the future of medicare in Ontario.

First, Bill 8 protects and promotes the accessibility of our public health care system. Accessibility is a tenet of the Canada Health Act. It is the notion that every citizen, regardless of economic means, where they live, their age

or ethnicity, should never be denied the health care they need. Ontarians and other Canadians tell us time and time again that accessibility is the health care issue that they care about the most. When it comes to health care, there's only one kind of Ontarian, and Bill 8 takes real action against two-tier medicine.

Bill 8 is transformative legislation because it reinforces the principles of the Canada Health Act by strengthening prohibitions against two-tier medicine. Bill 8 requires mandatory reporting of activities like queue-jumping and extra-billing and it gives the ministry greater ability to uncover potential instances of extra-billing and queue-jumping. For example, the general manager of OHIP would be able to collect key information from providers if they suspect that payment for queue-jumping has taken place. Today, consumers and providers who witness queue-jumping and extra-billing have no protection against reprisals if they speak up. Bill 8 would protect whistle-blowers who expose two-tier activities because we believe that the people who own the system ought to be involved in helping to defend it.

In the past, doctors were able to opt out of OHIP and bill patients directly for insured services. This bill puts an end to that practice. Bill 8 would make block fees that physicians charge for non-OHIP services more transparent. It guarantees that no Ontarian is discriminated against or denied care if they refuse to pay a block fee. It protects the consumer against excessive or inappropriate fees for uninsured services. Bill 8 poses a direct and potent challenge to two-tier health care.

You'll hear from some people over the next few days who have distorted the debate about Bill 8 and who say it gives government the power to privatize health care. They could not be more wrong. They could not be more misleading. Let's look at the facts. The bill is designed to root out and ban the activities that charge people for medically necessary insured services. It prohibits people from being able to pay their way to faster care. Bill 8 is about ensuring that medically necessary insured services remain publicly funded, publicly controlled and universally accessible, period. Full stop.

We decided to explicitly state in the bill that it will not allow collective agreements to be opened, or reduce or change the protections provided to workers under current labour laws. We did this to provide absolute certainty and allay the misplaced fears that some labour unions have created amongst their members. Collective agreements and labour rights were never a part, and never intended to be a part, of this bill.

One of the aspects of Bill 8 that I'm most proud of is the Ontario Health Quality Council. Our approach to government and to politics is to be clear about what we're trying to achieve, to be candid about how we want to get there and to be honest about the success that we're having. We believe that accountability is a cornerstone of the relationship between the government and its citizens. Our government has laid out a clear agenda for positive change. We stated where we intend to go, how we intend to get there and the results that people should expect. The

bottom line is this: We will be measured against what we promised, and we welcome that test.

As a government, we face scrutiny every day—from stakeholders, from the media, from the opposition in the Legislature, but most of all, from the people of the province of Ontario. Our democratic system holds us to account every day. But we want to go farther than that.

The Ontario Health Quality Council is the tool that will provide meaningful, timely, unbiased information to the people of Ontario about the state of health care and about the state of their personal health. Its purpose is to track continuous quality improvement. Ontarians have never before had a way of knowing how our system was performing. Hospital report cards and other sector-specific reports have given people some useful information on how different parts of the system are working, but there has been no mechanism that monitors and tracks health care performance as a whole.

Ontarians deserve to know the facts. Roy Romanow argues that results-based information is critical if health care is to be truly accountable to citizens. Roy Romanow said that accountability is the missing sixth principle of the Canada Health Act. Our government is correcting that by adding the principle of accountability to medicare.

Roy Romanow also proposed the creation of a Health Council of Canada as a mechanism to bring the provinces and territories together around measuring and reporting to Canadians on system performance. In a similar way, the Ontario Health Quality Council would monitor and report to Ontarians annually about how the system is performing in the areas that matter to people most, areas such as wait times for cardiac care, hip and knee replacements or cancer care, or whether they have a family doctor or family health care that's close to home. The council would report to people not only on access to publicly funded health services, but also on health human resources, population health status, and the prevalence of serious and preventable diseases such as diabetes. It would track rates of physical activity, obesity and smoking.

The council would enable people to hold the government and our health care sectors to account, and by helping people understand their health care better, it would enable Ontarians to take greater responsibility for their personal health.

The council exists to serve the broad and diverse interests of Ontarians. It would be composed of independent people drawn from our communities who are dedicated to the pursuit of quality health care.

The council cannot be allowed to be captured or sidetracked by narrow agendas or siloed thinking. We've made sure that the council does not represent individual stakeholder groups, but allows the broadest perspective possible to advance the agenda of our most important stakeholders—12 million Ontarians who are counting on us.

As I've said before, accountability is a two-way street, and Bill 8 effectively brings the notion of shared accountability to life. I'm glad to report that my ministry has worked diligently with hospitals through the joint

policy and planning committee to draft a framework for accountability agreements. When completed, the framework will no doubt form the basis of the accountability agreements we will be developing with all hospitals.

We look forward to continuing the public dialogue about Bill 8. We all have an enormous opportunity to deliver on Roy Romanow's vision. To quote Roy Romanow a few weeks ago at the RNAO annual general meeting, "Ontario's Bill 8 has some very important features that reinforce what we had in mind regarding accountability. It seems to me that Ontario wants to do the 'real work' required to ensure medicare sustainability. And Premier McGuinty played a key role in breaking the log-jam that led to the creation of the Health Council of Canada."

I'll close on the point, because I do believe this is work that has been inspired by the work that Roy Romanow did on behalf of our country, and I'm very proud to have his comment the last one as relates to my opening remarks.

The Chair: Thank you. Next we have the official opposition, 10 minutes.

Mrs Witmer: If I take a look at Bill 8 and I take a look at what I've just heard the minister say, I don't hear any comments regarding the amendments that have been made to Bill 8 and the willingness of the government to make additional changes to the legislation. Regrettably, many of the concerns that have been expressed have not yet been addressed. Despite the many, many nice words that both the federal and provincial governments have for the Roy Romanow report, we've seen little real action in response to that.

1610

I guess my question to the minister would be: You talk about two-tier, and you talk about the fact that this bill is going to eliminate queue-jumping or extra-billing. I would suggest to you that the key problem is the fact that the reason we have two-tier, the reason people queue-jump, the reason people do this is because the waiting lists are too long. And I guess one of the things I don't see addressed in this bill at all is the whole issue of waiting lists or an improvement in the access to care.

Hon Mr Smitherman: That seems like more of a comment than a question. Here's what I'll say to some of what you just said. Firstly, I did highlight some of the amendments we have made as a result of comments that have been made through this debate. Secondly, I don't want to prejudge what will be said over the course of the next three or four days of committee hearings, but I have sent the message—and I send it again today—that I'm listening. While I accept some of your point that concerns remain from some groups, I think there is also widespread acknowledgement, if I might characterize it, that the gulf of difference of opinion has been narrowed dramatically as a result of the amendments that have already been brought forward.

On your last point, I don't think it's very helpful or healthy to have the debate about Bill 8 turned into a discussion about everything a person might want in

health care. I've never suggested, as an example, that this is the health care bill for our government for four years. In part measure, we've already had Bill 31 on the health privacy side.

Wait times are a critical focus of our government. We're increasingly results-based. Romanow says there is progress. Romanow says this bill is progress toward his report, because in part measure his report called for bringing accountability as the sixth principle of the Canada Health Act, but I think his words stand well on their own.

My final point to you, to go back to what you said with respect to waiting lists, is we don't even have a mechanism for proper capturing of wait-time challenges as they exist on a region-by-region basis. I think you know that from your days as minister. But our drive toward that is really an essential ingredient in the Ontario Health Quality Council. I think that Romanow sees progress in Bill 8, but I'm not here to suggest to you that Bill 8 is the be-all and end-all for what our government is about but an important framing for much of what we intend to do.

Mrs Witmer: Thank you very much, Minister. On the issue of accountability, I guess one of the complaints we've heard over and over from presenters is the fact that this bill does not hold you accountable for your actions. Instead, it does bestow some tremendous power. I guess one of the questions I would ask, and I know it was a concern for the stakeholders, is why is accountability only a one-way street in this bill, if it's such a key principle of medicare? The accountability is only on the health care provider group; it's not on the ministry or the minister.

Hon Mr Smitherman: I wish I could answer a question with a question. Part of it would be, when you were the Minister of Health, did you feel a shortage of accountability? In a certain sense, that's what you're saying.

What I would outline is that there are many mechanisms for accountability that are already in the system. But I believe that a government that's willing to establish the Ontario Health Quality Council, which will on an annual basis report to Ontarians about the state of their health care system, is developing one of the most extraordinary tools of accountability that's ever been done in health care. The reason I believe so strenuously in that point is that in the six months and a few days I've been the Minister of Health, I've been astonished by the bevy of information that comes, the barrage on a daily basis, saying, "Make this expenditure and gain that benefit. Make this expenditure and gain that benefit."

Ontarians would be hard pressed to see through that and determine what priorities ought to be focused on. I think the Ontario Health Quality Council will play an incredibly effective role of actually making health care information accessible to people in a format they can come to terms with at a glance. Just as an example—I'm not ragging the puck—if we had an Ontario Health Quality Council report that showed a growing wait list on

a particular problem, that would stand out and would be an incredibly powerful source of accountability. As the public said, "Your commitment is toward continuous improvements on results. This is diminishing. What are you going to do about it?", that's accountability. That's what the Ontario Health Quality Council is about.

Mrs Witmer: Let's talk about the Ontario Health Quality Council because, regrettably, what your government promised in the speech from the throne was an independent council that would report directly to Ontarians, and what this bill gives us instead is a council that will report to you, who will then table a report in the Legislature. So this council has absolutely no power to make any recommendations. It's not independent; it's totally beholden to the Ministry of Health.

Again, this is a promise that simply has been broken, and I don't think people expect this council to have any teeth whatsoever.

Hon Mr Smitherman: Before you prejudge what the Ontario Health Quality Council will do, you should have something of a more open mind, because what I've said very clearly is that independence can be found in many different ways and, in part measure, independence can be found from the quality and reputation of the individuals who will form it.

The message I send to you, and that I send to Ontarians, is that we will harness among the capacity of Ontarians representatives who have capacity independence and provide confidence around the information they're presenting. We have made it clear that the information they develop and present in the form of their report is information that will of course be for the public of Ontario. I think that much independence will be found from the quality of the representation that we intend to appoint.

My last comment on this would be that that's why we've really staked this out as the territory for 12 extraordinary, impressive Ontarians, not representatives on a day-to-day basis as stakeholders here and there, but people who bring to their role a sense of responsibility and independence around presenting information that will be to the benefit of all Ontarians.

Mr Arnott: On a quick point of order, Mr Chairman: It's customary when a minister appears before a standing committee of the Ontario Legislature that the members of the committee are furnished with a copy of his or her comments. As of yet, we still haven't received a copy of the minister's comments. I'm not sure if it was deliberate or not, but it makes it more difficult for us to respond if we don't have a written copy. I was just wondering why we haven't as of yet received those copies.

The Chair: I understand they are being photocopied at this moment and they will be here.

That does bring us to the end. Thank you. Next, we have Ms Martel.

Ms Shelley Martel (Nickel Belt): I'm going to use the time I have to make comments in response to what the minister has said and to reinforce again the New Democrats' opposition to this bill. I'll repeat the points I

have made before because, frankly, they're worth repeating.

We oppose this bill for three reasons: (1) because of the arbitrary and unilateral powers that are given to the minister, despite the minister's assertions that accountability agreements will be negotiated; (2) because the bill does nothing to stop the ongoing privatization of health care that was started under the Conservatives and that, frankly, your party seems intent on continuing with; and (3) because there is a complete lack of any concrete power given to the health quality council to hold the government accountable. Let me deal with the three of those in that order.

First of all, with respect to the arbitrary, unilateral powers of the minister who has said on numerous occasions that accountability agreements will be negotiated, frankly, nothing is further from the truth, because the provisions in the bill after clause-by-clause still make it clear that the government has the unilateral right to impose either orders or compliance directives. I just want to highlight some of the sections to point that out.

Subsection (4) on page 25 says the following: "If the health resource provider and the minister do not enter into an accountability agreement within 60 days after the minister gave notice under subsection (1), the minister may direct the health resource provider to enter into an accountability agreement with the minister and with any other health resource provider on such terms as the minister may determine, and the health resource provider shall enter into and shall comply with the accountability agreement."

Page 27, subsection (4), "The minister shall consider any representations made under subsection (3) before making a decision to issue a compliance directive or an order under subsection 26(1)."

Subsection (2), page 28, under "Compliance":

"(2) The health resource provider shall comply with a compliance directive."

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Then on page 30 of the bill, under "Compliance" again:

"(2) The health resource provider shall comply with an order issued under subsection (1)."

Then with respect to "Directions," on page 32 of the bill, with respect to the CEO in particular, it says:

"(6) An order issued under subsection (5) may require the chief executive officer and health resource provider to comply with any directions set out in the order relating to any or all of the following:

"1. Holding back, reducing or varying the compensation package provided to or on behalf of a chief executive officer in any manner and for any period of time as provided for in the order and despite any provision in a contract to the contrary.

"2. Requiring a chief executive officer to pay any amount of his or her compensation package to the crown or any person.

"Compliance

"(7) A chief executive officer and a health service provider shall comply with the directions set out in the order."

It's not just me who is of the opinion that the minister, even in the amended bill, continues to have arbitrary and unilateral powers. The Ontario Hospital Association wrote to the minister on March 17, 2004, and committee members were copied. It says the following:

"While progress has been made, the amendments made on March 9 have not yet corrected what hospitals see as the most serious aspects of the bill. We believe further changes need to be made to sufficiently safeguard the critical role of community governance of hospitals.

"The central problem with Bill 8 is that it gives the provincial government the power to impose anything it likes on any individual hospital, bypassing hospital boards, the people who know the most about the hospital and the services it provides to the community."

Then the letter goes on to point out the sections that they think need to be changed and the particular section that they think should be dropped altogether. We'll hear more from them this afternoon. I'm not sure if that's still their position, but it certainly was as of March 17, after the bill had been amended.

This is a letter we received April 7, 2004, from North Wellington Health Care. It says the following:

"The ministry is steadfastly painting the picture that all is well and that with the help of the province, hospital governance will be fine. I have over 25 years' experience in hospital governance—and from that experience, I have concluded that will not be the case. We need, and historically have had, real governance at the local level by voluntary boards made up of community members. This is in tune with the rural and northern health care framework. If the public wants to knowingly change that governance model, so be it. The problem with Bill 8 however is that the change is being made in the shadow of that worthwhile and now ubiquitous term 'accountability.' The public (and likely some hospital board members) don't generally understand that. It is difficult enough now to recruit good, committed volunteer board members—if Bill 8 becomes law, as amended, I predict that current and prospective board members will decline the job of being local window props for the provincial level of government." Signed by G. W. Deverell, who is the board chair.

Again, that was sent to the committee members after the amendments that were made.

So it's clear to me both from the provisions of the bill and the response that we have received by the OHA, which normally acts on behalf of its member hospitals, and one particular hospital that I pointed out, that the powers of the minister continue to be arbitrary. There is no semblance of negotiation, and the government should, as I've said many times before, have an independent dispute resolution mechanism that can be used to deal with disputes. That way you're not seen to be taking over the community; that way both parties can have their say; and that way everyone lives with the response and

recommendations that come from someone or some body that is seen to be independent, because the ministry and the minister will not be seen to be independent in this regard.

Secondly, the bill is about protecting medicare. That's what the minister said, and he pointed to Roy Romanow's work to show that no one had done more to try and make public health care a public issue. I agree. I guess the problem I have is that I don't understand why this government continues down the road of privatization of health care services started by the former government. Let me give three examples.

P3 hospitals: The commitment that was made by the Premier before the election was very clear. Dalton McGuinty said the following to the Ottawa Citizen on May 28, 2003:

"What I take issue with is the mechanism. We believe in public ownership and public financing (of health care). I will take these hospitals and bring them inside the public sector."

The fact of the matter is, the only change we now have is that the Conservative mortgage has become a Liberal lease. We still now have the onus on the hospital and the board, through the operating grant, to pay a mortgage payment, where previously hospital construction and reconstruction would have been done through a capital grant, therefore never putting at risk operating funds, which should be dedicated and directed to patient care.

We're going to pay a whole lot more for the private sector to do this capital construction. We're going to pay more because the private sector consortium will have to borrow money at a higher interest rate than government will and because the consortium is not going to do this work for free. Of course the consortium is going to want a profit on top of the building costs. So the public pays more for the private sector to build a hospital or renew a hospital than we would if the government was doing so itself. And my argument continues to be that the hospital in Brampton and the hospital in Ottawa and any other hospital renovations and reconstructions that you're going to undertake should be done by the government through a capital grant. That way, we can ensure that money that should be going to patient care goes to patient care and doesn't have to be redirected to pay a mortgage, which is what's going to happen when it has to be paid through the operating grant.

Secondly, and I raised this with you last week in question period, Minister: the whole issue of the private MRIs and CAT scans. You will know what your government had to say in your health care platform about both of these things and you will know that you clearly made a commitment that you would close these private sector clinics. You said:

"We will cancel the Harris-Eves private clinics and replace them with public services. The Romanow commission proved there is no evidence to support expanding private diagnostic services."

"Many communities have already raised money for a new MRI or CT for their local hospital but have been

denied operating funds by the Harris-Eves government. Instead of opening private clinics, we will work with these communities to expand access in the public system."

Six months later, we're still waiting. We need to shut these down. You need to put this technology into the public health care system, and you need to do that by providing the operating funds to those hospitals that have already raised the capital funds for that technology.

The third problem with privatization is the murmurings and the musings about ending the universality of the drug benefit program. If you do that, people will pay user fees, which will be exactly contrary to the preamble stated in the bill.

The final note on the health quality council: If you really want to give this group some teeth—and I have no doubt you will find excellent people to serve—you will allow them to make recommendations on their findings. You will allow them to make recommendations to you with respect to the spending of health care dollars, the allocation, changes to government policy, changes to government health care legislation. If you don't, their work will be for naught.

The Chair: Thank you. That brings us to the end. Thank you, Mr Minister, for your presentation.

CAW CANADA

The Chair: Next, we have the Canadian Auto Workers. We have three representatives, I believe. Just make yourself comfortable at the table.

Before making your presentation, please state your name for Hansard. I'd also like to remind you that there will be a time period of 15 minutes for your presentation. If you don't use the 15 minutes, then we will have a round of questions, starting with the official opposition, the third party, and to the government side. Should we only have a minute, we will start with the official opposition and then the next time we only have a minute we'll go to the third party and work it that way.

I welcome you, and you have 15 minutes for your presentation.

Mr Paul Forder: I'm Paul Forder, the director of membership, mobilization and campaigns for CAW Canada. With me to my right is Corey Verhey, our national representative on health care issues in the research department; and Darlene Prouse, vice-president of Local 2458, a health care local that stretches from Windsor to the southwest, with 4,000 members.

It is indeed a pleasure to be back before the committee. We'll keep coming back as long as you are open to some suggestions so we can try to get this right. We believe this is essential to the well-being of Ontarians, and we know you agree.

You've probably heard as many opinions as you have had presenters. We do represent 180,000 members in Ontario, 20,000 of whom are health care workers. So you can see this interest for us as representing workers in the industry, as well as being people who enjoy the benefits

of a good health care system. We require having more dialogue and hopefully trying to impress upon the committee the importance of our particular views.

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Our comments today reflect the understanding of the act and are based on Bill 8 as debated and carried to second reading prior to being referred back to the standing committee. The tabled amendments to Bill 8 by the Minister of Health and Long-Term Care generally provided the specific language for potential changes mentioned in the February 19 letter from the minister to the standing committee.

In overview, while the vast majority of the adopted amendments indeed did reflect the minister's announced intention to address concerns of our union and many other organizations and individuals, the amended Bill 8 remains far from being complete. For completeness, to accurately reflect the commitment to the future of medicare that the current government campaigned so earnestly to express and defend and that the public in Ontario clearly endorsed in October 2003, we believe the following has to be taken into account and incorporated into the act:

(1) That concrete initiatives were receiving legislative enactment to apply the fundamental principles of the Canada Health Act;

(2) That the legislation would clearly prohibit public-private partnership schemes (P3s) and ensure an immediate return of testing being performed in private diagnostic clinics to hospitals—we really are at a loss as to why this cannot be entertained;

(3) That the legislation would clearly enshrine as a public policy goal in Ontario a determination to end the creeping privatization that has occurred in recent years;

(4) That the legislation would ensure that the proposed health quality council be an objective body with a democratic appointment process, including a prohibition of membership by for-profit providers, and a requirement to report to the public and make recommendations on how the provincial health system meets the principles of the Canada Health Act;

(5) That the legislation ensure effective accountability of the health institutions and the Minister of Health to the people of Ontario, including democratic control, meaningful public input and consultation, transparency and full disclosure of whistle-blower protection;

(6) That the legislation clearly eliminate such practices as block fees and any other form of patient charge or fee, delisting and queue-jumping for what purportedly are medically unnecessary procedures;

(7) That the legislation lay the foundation for a robust and collective effort to build and extend the values and foundation of medicare to ensure a high-quality, accessible, publicly delivered health system capable of ensuring effective services and outcomes.

We acknowledge that the changes to the preamble in Bill 8 is an effort to ensure a balancing of the public interest or community with the imperative of efficient delivery, as well as a replacement of the term "con-

sumer" with that of "individuals." Both are welcome changes but of little substantive effect. The substance of our earlier submission on the inadequacies of the preamble in such a significant legislative tribute to the fundamental values Ontarians hold remains germane.

Mr Corey Vermey: I would like to just take the committee members through a number of key points and observations in our submission. The first is with regard to the health quality council. The key argument that we wish to present to you is that fundamental to the role of the council must be an accounting, an annual report to the public in Ontario of the extent of privatization in our health care system.

We have specified how that could be achieved, consistent with our understanding of the requirement by the federal government under the Canada Health Act. Surely, if the commitment is to at least assess, if not stop, the creeping privatization, we have to measure it and acknowledge in what direction it is moving. So we would urge the committee members to again look at that issue and find it within the mandate of the council to provide that information to the public in Ontario.

We are reiterating earlier comments. With regard to the candidates for the council, we are somewhat concerned with the new elements in the definition. We would be concerned, for instance, that very reputable individuals in the field of health policy, by virtue of their association with organizations such as the Ontario Cancer Society or, for that matter, the Ontario Nurses Association, would be precluded from membership on this council, but another individual such as Michael Kirby, who sits on the board of Extendicare, may in fact be eligible for membership by virtue of his role as a member of the Senate of Canada. We believe that definition needs to be reconsidered and the intent of the language clarified. Obviously, the government will have the discretion in making the appointment, but we believe that there are a considerable number of esteemed individuals—Roy Romanow is certainly a lead individual in Canada, but in Ontario many others come to mind—who, as advocates for the expression of our commitment to medicare, would do well on this.

The related comments, again, turn to the issue of the role of experts in this council and its size. Certainly, we believe both can be gainfully reconsidered with a view to the importance that many have already expressed this afternoon that the council should attain in this province.

On the issue of accessibility, our contribution, hopefully, to the work of the committee is to specify some of the key elements of whistle-blower protection. We acknowledge that there is provision in the act for whistle-blower protection. Regrettably, it is very specific to provisions of the act dealing with block fees, dealing with queue-jumping, dealing with specific practices. We submit that, in a bill such as this, with regard to accountability the whistle-blower provision should be a very general provision that makes legislative room in this province for the employees in the system to step forward when in the course of the performance of their duties they observe matters that, in good faith, they believe the

public in Ontario should be aware of and the government in Ontario should take action on.

Mr Forder: Darlene Prouse will do our wrap-up.

Ms Darlene Prouse: In conclusion, we commend the government for its commitment to securing the future of medicare in Ontario through adoption of several of the recommendations of the Romanow commission. As the Minister of Health stated to the Legislature on November 27, 2003, in presenting Bill 8, the Romanow report came to one pivotal and irrefutable conclusion: the pursuit of corporate profit weakens—not "strengthens"—health care.

However, on March 23, when Minister Smitherman rose to move second reading of the bill, at no point did he refer to the threat of creeping privatization, the threat of corporate profits weakening health care in this province. In the past month, thousands of concerned members of the public gathered at Queen's Park to urge the government to hold to its commitment to end P3 hospitals. In recent days, the pre-election Liberal commitment to close for-profit MRI and CT scans and expand accessibility in the public system was jettisoned by the minister when he indicated that he is not prepared to force for-profit MRI clinics out of business.

In recent days, nursing home operators began announcing layoffs among their nursing staff in response to the reduction in supplementary funding for municipal property tax expenses. In recent days, several municipal homes for the aged have reconsidered their original intention to rebuild non-profit long-term-care facilities due to lack of provincial capital funding support.

The test of Bill 8 in recognizing the legacy of the deep and profound commitment of Canadians to medicare is the ability of the people of Ontario to hold their government and health care providers accountable for strengthening health care and resisting the creeping privatization that threatens access, quality and sustainability of universal public health care. We agree that medicare is the best expression of Canadian values. However, any effort or intention to renew and transform medicare to make it sustainable for future generations must confront the unsustainability of permitting further for-profit encroachment in this vital area.

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Mr Forder: We'd be happy to take questions.

The Chair: We have about four minutes, so a quick question from each caucus.

Mr Arnott: Thank you, Mr Forder, to you and your colleagues for coming forward and expressing again to this committee your views on Bill 8. The opportunity that you had today is due in no small part to the efforts of our party's health critic, Elizabeth Witmer, and the good work she did when we concluded the government was unprepared to move forward with some of the amendments we felt were important. As a result of the public hearings, we, as a party, called upon the government to refer this bill in its amended form back to this committee. So you've had a chance to have another kick at the cat, so to speak, and express your views on the amended bill.

You've said that you feel the bill is still "incomplete"—that's the word you used. I'd like you to summarize again very briefly what you see lacking in this bill, specifically as to your role in representing your 20,000 members who are health care workers.

The Chair: Briefly.

Mr Forder: We need some toughening up on the whistle-blowing protection. We need a safeguard.

We have to get away from having any part of the health care system privatized—that's either through the delivery or the building. It should remain in the public domain. We learned from the Honourable Minister Pettigrew how sensitive an issue this is across the country. I hope this committee gets it right; I hope this government gets it right. I think they're on the right track.

We also think that this council has to have some authority to report on what's happening, to follow up on the recommendations and to make recommendations to the minister that will enhance medicare and the future of public health.

Ms Martel: I want to focus on privatization. The minister, in his opening remarks, said, "Bill 8 takes real action against two-tier medicine." In the province of Ontario, we still have P3 hospitals, and he made it pretty clear last week that he was in no hurry to shut down the private MRI-CAT scan clinics. There are no provisions in this bill to shut them down. There are no provisions in the bill to shut down the P3 hospitals either. What do you think about a bill where the minister purports to protect medicare through the bill when there are absolutely no provisions to do that, and further, when the direction of the current government seems to be very much like the direction of the old?

Mr Forder: That is our biggest disappointment. We believe that they didn't create the problem, but they can, in fact, with the power they have today, shut the door on P3s. It's not there, it's not evident, and this is not going away. I can tell you that in our membership this is the number one issue. We were participating in the P3 demonstration not long ago. This issue will not go away until we get it right, so that people have the assurance that it will remain in the public domain well into the future.

Ms Monique M. Smith (Nipissing): On the membership of the Ontario Health Quality Council, you made reference to people who had affiliations with different organizations and might not be eligible. I would just draw your attention that the bill states it's only those who have a position of "A member of the board or the chief executive officer or an officer of a health system organization may not be a member of the council." Just because you're a member of ONA or a member of the CAW doesn't mean your affiliation would disqualify you from being on the board.

Conversely, you made mention of the fact that Senator Kirby would be allowed to be on the board despite the fact that he's on the board of Extendicare. That, in fact, is not correct, because he is on the board of a health system

organization. Sorry, I have to get back into the lingo; it's been a couple of weeks. The health system organizations are defined in the act as "any corporation, agency or entity that represents the interests of persons who are part of the health sector." Therefore, as a member of the board, he would be disqualified. I just wanted to clarify that for the record.

Mr Vermey: We're very grateful for the clarification. We were concerned how the government would consider Michael Kirby as a candidate for the council, and it's reassuring to hear what you've expressed.

The Chair: Thank you very much for your presentation. Have a good afternoon.

YORK REGION HOSPITALS JOINT EXECUTIVE COMMITTEE

The Chair: Next we have the York Region Hospitals JEC, Damian Bassett, the chair. Welcome. Make yourself comfortable. You will have 15 minutes. You can use it as you like. If there's time remaining, we'll do as we just did and have questions. We'll be starting with the third party.

Mr Damian Bassett: Thank you, Mr Chair. Good afternoon, ladies and gentlemen. It's my pleasure to be here. My name is Damian Bassett. I'm the past chair of the Markham Stouffville Hospital. I've spent nine years on that hospital board, with three of those years as chair. I'm currently on the board of the Unionville Home Society.

I'm here today in my capacity as chairman of the York Region Hospitals Joint Executive Committee. Our member hospitals include, in addition to Markham Stouffville, York Central Hospital in Richmond Hill and Southlake Regional Health Centre in Newmarket. Although the Health Services Restructuring Commission formalized the joint executive committee of our hospitals in 1997, we have in fact been working collaboratively for many years prior and have enjoyed great success in attracting new health care services to York region and in sharing others. Examples include implementing a shared MRI in 1997, shared specialist physician on-call coverage between our hospitals, regional geriatric consultation and regional speech therapy. More recently, we have achieved significant success in our joint presentation to York regional council and their support of our respective hospital development projects.

As a group, our hospitals are committed to working together to achieve clinical and financial efficiencies and to expand the availability of secondary, tertiary and regional programs closer to home for the residents of York region. Ultimately, we believe it is in our collective interest and responsibility to improve the delivery of health care in York region to ensure that we can meet the needs of our very rapidly growing population.

We appreciate having the opportunity to speak to you today to present several continuing and significant concerns with respect to Bill 8. You may recall that both York Central Hospital and Southlake Regional Health

Centre gave presentations to this same committee on February 25, and we are very encouraged by the amendments that were introduced to the bill following those hearings.

Several major concerns remain outstanding. They are primarily to do with provisions in sections 26 and 27. Section 26 gives the minister the authority, 30 days after notice of non-compliance, to issue an order to a health resource provider. The order may be to comply with any directives set out in the order; to comply with any part of a compliance directive; to hold back, reduce or discontinue payments to a health resource provider; to require a health resource provider to enforce any provision of a performance agreement with a CEO; or to vary any term of agreement as set out in the order between the crown and the health resource provider.

We understand that the provisions of this section apply to the negotiation period of the new accountability agreement between the minister and the health resource provider. From a very practical perspective, it is unreasonable indeed to expect that the ministry will be able to negotiate accountability agreements with 150 hospitals, 43 CCACs, over 500 nursing homes and others in a manner that will not result in the majority of health resource providers finding themselves non-compliant from the outset. Sixty days provides little opportunity to negotiate an agreement as significant and complex as this. The proposed remedy—the ability of the minister to invoke section 26 to order a health resource provider to sign an accountability agreement on terms determined by the minister alone—is inherently unreasonable and unjust, and impedes the good-faith negotiations and relations with ministry staff that so many have worked so hard to achieve. It surely cannot be the ministry's intention to subvert the process of true negotiation and impose accountability agreements on health resource providers by proposing such an unwieldy and unworkable process. And yet, given the sheer number of agreements to be negotiated, the ministry may have no choice but to allow the 60-day period to expire for many.

Our second concern with section 26 is the absence of any impartial appeals process. We strongly recommend the addition of a legitimate review mechanism utilizing either a mediation or arbitration process, with the recommendations binding on the ministry and, in our case, the hospital.

Our third concern with section 26 relates to the imposed interference between the CEO and the board of the health resource provider. In this case, we are referring to an order that requires the health resource provider to enforce any provision of a performance agreement with a CEO. In our view, it is up to the board to determine what kind of binding contractual arrangement it has with the CEO. It is not appropriate for the Minister of Health to impose directives on a board that include the requirement to transpose those directives on to the CEO.

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With respect to section 27, we understand that when there is a change to a CEO's terms of employment as a

result of the health resource provider entering into a performance agreement, this section provides that the CEO shall be deemed to accept the change without compensation, and apparently without recourse through alternative legal avenues. We find this provision to be particularly punitive and contrary to the intent behind the effort to enhance our substantive accountability. It is our view that the hospitals in York region have always been accountable—to each other, to the Ministry of Health and Long-Term Care and to residents in our communities who rely on us for high-quality health care services close to home. It has always been acknowledged by the investments made to renew and expand our hospital infrastructure—investments made by the provincial government, our regional government, and our community members through their various and vast fundraising efforts.

For many years, the hospitals in York region were also among the most efficient in the province. For example, in 1997-98, all three were ranked in the top 20 from the 120 or so hospitals in their peer group. We acknowledge that our relative efficiency rankings fell over the past few years, and we believe this is related, at two of our hospitals, to our attempts to accommodate extreme growth pressures in outdated and inefficient buildings while at the same time undergoing extensive renovations and redevelopment activities. In addition, the expansion of tertiary regional programs has produced significant implementation and learning costs. We acknowledge that we have ground to make up; however, we remain committed to improving the financial performance of these new programs and of our hospitals overall.

I thank you on behalf of the three hospitals in York region for the opportunity to present our feelings on these sections of Bill 8.

The Chair: Thank you. We have eight minutes remaining, so I'll split the time.

Ms Martel: Thank you for coming here today, Mr Bassett.

The minister has said on more than one occasion that accountability agreements are going to be negotiated. He said that publicly; he said that to this committee. When you read the provisions of the bill, do you get some comfort at all that these are going to be negotiated? Do you have any sense of that, given the provisions in the bill?

Mr Bassett: Our reason for being here today is to take the minister at full face value and to expect that the opportunity presented through committee hearings, through submissions of this sort, will result in the modest changes, I think, that we're proposing to this bill. You'll note that our comments are restricted at this point to those two areas in which we feel the bill in its current form has fallen slightly short.

Ms Martel: Would it be your view that those two sections should just be deleted from the bill?

Mr Bassett: No. I think our hospital understands the need for the accountability agreements and supports them. We believe we've identified a shortcoming in the

process to ensure compliance and to ensure the appropriate form of negotiation and consultation so that we're not forced to be in a non-compliant situation which doesn't benefit any of the parties.

Ms Martel: So in the sections that you've referenced, you would need some reference to an impartial appeals process, binding arbitration—

Mr Bassett: Mediation.

Ms Martel: Mediation. I'm assuming you want some changes around the minister's ability to deal with your CEOs as well.

Mr Bassett: Again, further consultation and the ability to understand contractual commitments and have the process respected. The current structure of governance in the hospitals in Ontario does empower the board in each hospital to negotiate those contracts with the CEO.

Ms Martel: And that has to remain in your power.

Mr Bassett: At this point in time, that would be our position.

The Chair: We'll move to Ms Wynne.

Ms Wynne: Thank you for coming, Mr Bassett.

I want to step back from the piece that you've just been talking about with Ms Martel. I'm making an assumption that you think introducing accountability into the system, or more accountability—I understand you've said that the hospitals have always been accountable, and I accept that. But you're not opposed in principle to the introduction of further accountability into the system?

Mr Bassett: Not at all.

Ms Wynne: OK. I guess I was a little disturbed that you make a blanket assumption that there's going to be non-compliance or that there's going to be a problem. My assumption would be that there will be ongoing dialogue between the ministry and the hospitals and the components of an accountability agreement will be ongoing. It won't be a discussion that starts on the first day of that 60 days. So I'm just wondering why you would make that assumption that there will be massive non-compliance, or potential non-compliance, around the province.

Mr Bassett: With all respect, we do operate in good faith on both sides, Ms Wynne. We assume that the government, the ministry and the minister will enter into these discussions with an intention to find an appropriate resolution and not to be non-compliant. But we're also facing the stark reality of the calendar. The program years effectively start for each of the institutions that I referenced at the same time, and 60 days puts all of them at the same point in the calendar process. The reality is that the majority of hospitals in this past year were unaware of their funding through the budgeting process for perhaps 90 days beyond the start of their fiscal year.

All we're suggesting is that the anticipation be put in place that in the event that the timetable proves to be too strenuous for all the parties, it not automatically result in a forced solution when we believe the intent of all parties was to negotiate a solution. I think that just building in the provision for an arbitration or mediation process

would indicate not that it becomes the preferred course, but that it would at least be available in the event that the timetable were to overcome you, notwithstanding the best wishes of all parties.

Ms Wynne: But the other piece of that would be some reassurance that the logistics of these negotiations or conversations would be worked out in a reasonable manner and that they wouldn't be expected to be sequential, that they could be done within the 60 days. You want some reassurance that they could actually be done in the 60 days. Is that what you're looking for?

Mr Bassett: That's it exactly. We don't want to create an incentive for either party—and pardon the basketball analogy—to run the clock.

Mr Arnott: Thank you, Mr Bassett, for your presentation today. I'm really pleased that you've had this opportunity to come in once again to express the views of the hospitals that you represent with respect to the amended Bill 8, because I think it's important that we continue the dialogue in the hopes that the minister and the Ministry of Health will listen to what the health care providers have offered in the way of advice.

You mentioned the number of accountability agreements that would have to be negotiated in a very short period of time, and I would very much question whether the ministry has the resources to do individual accountability agreements. So most likely there's going to be some sort of a framework that will be for large hospitals, and maybe some small alterations considered.

The thing that concerns me the most is the idea of the discussions, the so-called negotiations, that might take place, because there's no way there can be a level playing field in terms of these negotiations unless the government listens to the hospitals' suggestion that there be some sort of impartial appeals process which is binding upon both the government and the hospitals. Have you any thoughts as to how that process might be set up? How would we set up a binding appeals process?

Mr Bassett: There are those who are more learned than I on that structure, but I know the hospitals that I'm speaking on behalf of would be happy to participate in any sort of a facilitated session to arrive at such a conclusion. We're also supportive of the Ontario Hospital Association, as it's made known some concerns in this area too. So a bringing together of the stakeholders in this particular arena that stand to benefit most from negotiated settlements and the ability for the hospital system to work uninterrupted by these mandatory conformance requirements would be in our interests.

Mr Arnott: This afternoon, the minister told the committee that the ministry is working through the joint policy and planning committee to draft a framework for accountability agreements. Have you heard about the progress of these discussions?

Mr Bassett: I haven't personally, but that doesn't mean that some people within the three hospitals haven't.

The Chair: Thank you very much for your presentation this afternoon, and I wish you a good rest of the afternoon and evening.

ONTARIO HOSPITAL ASSOCIATION

The Chair: Next we have the Ontario Hospital Association: Ms Hilary Short, president and chief executive officer; and Mary Lapaine, past chair and trustee for the Goderich general hospital. Welcome. Once again, you will have a 15-minute period. I would ask that you identify yourselves for Hansard at your presentation, and the time remaining will be split between the parties for questions.

Ms Mary Lapaine: Thank you very much and good afternoon. Thank you for having us here. I am Mary Lapaine. I am the immediate past chair and current board member of the Ontario Hospital Association, and I am also a trustee with the board of directors at Alexandra Marine and General Hospital in Goderich.

With me today are Hilary Short, our president and CEO, and Sheila Jarvis, chair-elect of OHA and president and CEO of Bloorview MacMillan Children's Centre.

Ontario hospitals are leaders when it comes to accountability. Ontario is the only province in the country with hospital report cards. It was the hospitals of Ontario that first advanced the idea of accountability agreements with the provincial government more than two years ago. From financial performance to patient satisfaction, hospitals have never been afraid to answer questions about how they do their job. Ontario hospitals are also leaders when it comes to efficiency. Just last week, we released two studies that show Ontario hospitals are more efficient than their peers in other provinces.

Given the serious and principled nature of our concerns about Bill 8, we are very pleased that additional public hearings are being conducted on this proposed legislation. We are here to provide constructive advice to the committee. This proposed bill is far too important not to get right. It will have far-reaching implications for hospitals and the wider health care system for many years to come.

As you well know, when Bill 8 was first introduced, we had a number of very serious concerns with the bill. We are pleased that the bill has been amended so significantly since that time. The OHA favours many of the changes that have already been made, especially the amendments that ensure the public interest is considered when the government considers using the bill's accountability provisions. We also favour the change that ensures accountability agreements are established between the minister and the board, not the CEO.

Hospitals want to work with the government so that it has the tools it feels it needs while maintaining the fundamentals of good governance. This is at the heart of the issue for trustees across Ontario. We believe we can strengthen accountability in the province without undermining the role of the hospital board, which this bill continues to do.

We were delighted to hear the minister on two separate occasions last week strongly endorse the role of

voluntary hospital boards throughout Ontario. Local boards play a critical role in representing their community, take their job seriously, and are actively keeping abreast of the issues through educational opportunities such as OHA's Health Care Trustee Institute. Hospital boards are very aware of community needs, but they also keep in mind their financial responsibilities to the taxpayers of Ontario.

As incoming chair of the Canadian Healthcare Association, I have had the opportunity to hear the experiences of my counterparts across Canada. They have told me that by and large they have not found government board appointments to be advantageous. We should value the tremendous contributions our volunteer board members play in advancing patient care needs in their community.

Now Hilary would like to tell you some of our proposed solutions.

Ms Hilary Short: OHA is committed very strongly to supporting initiatives that further advance governance and accountability in Ontario. We are collaborating very productively with the government in the development of accountability agreements through the JPPC, the joint policy and planning committee. You heard the minister reference this earlier in his talk.

We, the OHA board, have now endorsed the framework developed through the JPPC for accountability agreements that will be used in 2005 and 2006. We're very pleased to announce that here today. That accountability agreement, in fact, proposes a ladder of remediation that would culminate, as Ms Wynne has said, with the enactment of Bill 8, and beyond that the Public Hospitals Act. So with the culmination of the accountability agreement remediation provisions, Bill 8 in its amended form and the Public Hospitals Act, I think the government can be very satisfied that there are provisions to deal with any incident where difficulties arise.

We are going to establish a governance leadership council here at OHA, a panel of distinguished experts to guide our education programs and to provide tools and templates that support excellence in governance. But to preserve good governance, we are also seeking amendments to Bill 8 that will achieve the government's objectives while enhancing local community governance. A copy of our proposed amendments is included in the material distributed to the committee members.

Here are our proposals:

First of all, on section 21, the imposition of accountability agreements, which continues to be a serious problem. Currently, the legislation enables the minister to impose an agreement on a hospital in the event of a dispute. OHA had originally proposed that there be a dispute resolution process, which the minister felt would be too cumbersome. As an alternative, therefore, to imposing the agreement after 60 days, the OHA is proposing that the matter be referred to an independent commissioner, or panel of commissioners, chosen from a roster, appointed by the minister with input from hospitals.

The commissioners would review the matter and issue a report and recommendations quickly. We are suggesting at this point that it be within 30 days. This report would be made public. This process would provide for a true third party review in a manner that is streamlined to ensure expedient resolution of the matter. In addition, it would provide the parties with independent advice and give the sector valuable information respecting how disputes over the agreements are being addressed. The commissioners would have the authority to deny a review if they felt a review was not in the public interest.

Another important amendment, we believe, would be to ensure that at the end of the day the power to impose the agreement be made by order in council, or alternatively, that it be subject to ministerial approval.

Secondly, let me turn to our suggestions with respect to 26 and 27, which we refer to as the issue of preventing blurred accountability between the CEO and the board. Instead of the sanctions set out in sections 26.1 and 27, the OHA is proposing that Bill 8 be amended to make more explicit the lines of accountability between the minister and the board, and between the board and the CEO, via the performance agreements provided for in the bill.

We recommend that the accountability agreements between the minister and boards be required, that the boards be required to implement CEO performance agreements that would include performance objectives and regular monitoring capabilities—this could be achieved by amending section 21(5) to make the performance agreement between the board and CEO mandatory—and also developing a regulation specifying some of the key components in the performance agreements between hospital board and CEO.

Further, if the minister wanted to review the performance of a CEO, the minister could request the board to appoint a commissioner or commissioners, as we referred to before, to conduct a review of the CEO's performance. Alternatively, the board could unilaterally appoint a commissioner to conduct a review of its CEO without the minister's approval.

We think the appointment of this third party roster of commissioners could provide the government with what it needs: speedy resolution where a dispute is in play, without interfering with good governance or interfering in affairs which are more properly the responsibility of the board.

In our view, making these changes would eliminate the need for the proposed control mechanisms in sections 26.1 and 27 of the bill, which would have a counterproductive effect on hospital governance and accountability.

Finally on the issue of physician payments, which is section 9: The original bill prohibited such payments. However, hospitals depend on their ability to pay physicians for certain specific programs. The amendment proposed, however, makes it too wide open.

This is a complex issue. We believe that the matter of payments by hospitals to physicians cannot and should

not be resolved by means of legislation. These payments are, and continue to be, the subject of considerable debate within the ministry, the OMA and the OHA, and all parties currently are actively engaged in seeking an appropriate resolution to this issue through a combination of the current OMA negotiations and other venues.

Accordingly, we recommend that section 9 be deleted in its entirety. In addition, we would propose that a tripartite body be established to study and resolve issues of hospital payments to physicians on a provincial basis. The solution we need is to ensure payments are negotiated on a provincial basis so that individual hospitals are not whipsawed by demands or requests from their physicians.

With that, I'll ask Sheila Jarvis to conclude.

1710

Ms Sheila Jarvis: I'm speaking to ensuring timely access to care. Hospitals are proposing that the right to timely access to health care be incorporated in this proposed legislation. When people come to a hospital in need of health care, hospitals don't turn them away. We have a duty to provide timely care to our patients, and we feel very strongly that this principle needs to be included in the Commitment to the Future of Medicare Act for the legislation to live up to the promise of its title.

If wait times cannot be specified in the bill, then hospitals recommend that at the very least the definition of "public interest" be expanded to include a clear and definitive statement about the crucial importance of including timely access to care as a key factor for the government to consider when it is thinking about using its power under this proposed legislation; otherwise, there will be no legislative provisions in the bill to hold the government accountable for service levels.

Timely access to health care services is the cornerstone of our medicare system. Incorporating it into this bill would send a powerful message to the people of Ontario about this government's priorities as it moves forward with its May 18 budget and makes decisions about the future of this most cherished of our national institutions.

Thank you for your time. We'd be pleased to answer questions.

The Chair: We have about three minutes remaining. Perhaps we'll take one quick question from each party. It's the government side.

Mr Jeff Leal (Peterborough): Ms Short, physician payments: Are we talking about hospitalists there?

Ms Short: No, we're not. The original bill prevented hospitals from making payments to physicians at all. Clearly, as you say, hospitals need to make payments to physicians under certain circumstances. Then the amendment laid it way open. We need to have a way of settling disputes about how hospitals are going to make those payments to physicians and have some provincial approach to it, so that individual hospitals are not approached by their physicians. Yes, indeed, they do need to pay hospitalists; many of them are on salary, which is a little different. We need to work out some of

these new ways of making sure that hospitals are able to get the physician services they need but look at the issue on a provincial basis.

Mrs Witmer: I just have a question about accountability agreements. Obviously, we don't want the minister/ministry to be able to impose agreements after 60 days. You've suggested here that the issue should be referred to an independent commissioner. Could you just give me a little bit more information? What's the rationale for this, and how is this going to still ensure accountability?

Ms Short: The issue behind that is that if they are truly negotiated accountability agreements, there needs to be a dispute resolution mechanism. We had suggested originally a number of options, including binding arbitration, which had been rejected as being too cumbersome and time-consuming.

We're suggesting something that would provide the minister with what he needs in terms of speedy resolution to this while also preserving good governance, so that this would be a compromise, if you like, where you'd have a third party of experienced people who are accustomed to doing this. They would be appointed and they would be able to help us resolve that. They would be able to report expeditiously, and then there would be the ability to make a decision, but there would be some third party review, and it would protect the hospitals from what they see as arbitrary decisions.

The Chair: One quick question, Ms Martel.

Ms Martel: You've suggested a number of options, because we saw this kind of language in the first bill and we see it yet again. I read into the record earlier some of the comments in your March 17 letter. You've got some proposals on the table. What will the situation be, though, if the government doesn't move off the provisions in the current bill? What will that do to you as an association, to your board members, who are very concerned about being taken over and not having negotiated settlements?

The Chair: One minute.

Ms Short: We fear very much that this will undermine governance and that it will be a demotivating impact on people serving on hospital boards. We have a trustee here who can testify to that. That's our big concern, that in its present form it does sort of undermine the whole concept and the principles behind voluntary community governance of hospitals.

The Chair: Thank you for your presentation this afternoon and have a good evening.

REGISTERED NURSES ASSOCIATION OF ONTARIO

The Chair: Next we have the Registered Nurses Association of Ontario: Doris Grinspun, executive director. You will have 15 minutes for your presentation. Should you not require the 15, we will break it up, as we did, with questions from each party, and we'll be starting with the opposition. Welcome.

Ms Doris Grinspun: Thank you very much. Good afternoon. My name is Doris Grinspun, and I am the executive director of the Registered Nurses Association of Ontario.

RNAO is the professional association of registered nurses across the province. Our mandate is to speak out for health and to speak out for nursing. In doing so, we advocate for healthy public policy and for the role of registered nurses in shaping and delivering health services. We welcome the opportunity to comment on Bill 8, as it has significant implications for Ontarians and for the profession. We will comment on each part of the bill.

First, the preamble: In its preamble, the bill endorses the Canada Health Act, primary health care, pharmacare for catastrophic expenses and home health care, and accountability. We believe this is actually quite excellent. RNAO endorses, of course, all of the recommendations in Romanow's final report on the future of health care in Canada, and we expect our government to do the same, as it has promised every single time.

We are concerned, however, that the content of the bill does not include these positive elements of the preamble. Indeed, the bill fails to address how it will protect medicare and how it will expand primary health care, home health care and pharmacare. The bill also makes no mention of the government's promise to ban for-profit MRIs and CT scan clinics, or put a stop to P3s.

The only concept to support the Canada Health Act that's included in the bill is enhanced accountability. RNAO very strongly supports the need for enhanced accountability. We also urge the government to deliver, though, on its promise to implement the Romanow report in Ontario through Bill 8. We would like Bill 8 to explicitly ensure that MRIs and CT scans are dedicated only for medically necessary services and that delivery is not for profit. It must also serve to prohibit the continuation of P3s until they prove that they provide better quality at a better price, which is not the case, as we know from all the studies at this point. A bill that does not include these key features can in fact serve to undermine the long-term sustainability of medicare. The bill must explicitly include the public's right to access primary health care, to access home health care, and to access catastrophic drug coverage. RNAO is eager to work with the government to address these vital gaps in Bill 8 as it currently stands.

Establishing the Ontario Health Quality Council: RNAO is pleased with the government's commitment to form an Ontario Health Quality Council. We see this as an important step forward in supporting the Health Council of Canada, a key recommendation of the Romanow commission and an essential element to protecting the Canada Health Act. RNAO strongly recommends that membership in the council be determined through a transparent and democratic process that would serve to build social cohesion and select the best representatives.

RNAO would like to see the scope and functions of the council expanded. Bill 8 proposes that the council

only report on access and quality issues, and support quality improvements. These are indeed essential functions but are not sufficient to support system accountability and the sustainability of medicare in the long run. We believe the council must also report on cost-effectiveness of programs. Specifically, we are asking that the key outcome indicator be cost-benefit of for-profit and not-for-profit delivery.

We ask that the council be truly independent, with the mandate to write recommendations to the Legislative Assembly. These recommendations should also be included in the council's public reporting.

1720

Part II, health services accessibility: Guaranteeing equal access to health is an absolute core value and a key component of Bill 8. Thus, RNAO applauds the continued ban on extra-billing. Regulating block fees is a step forward, but RNAO endorses the urgent call by the Medical Reform Group to fully ban block fees. Until the government is able to ban these fees, we recommend that doctors who continue to charge block fees be required to post government-designed posters specifying which services cannot be included in block fees, and the complaint procedure in the event of policy violation. While block fees will be regulated under Bill 8, the bill fails to regulate how much physicians can charge. We urge the government to correct this. RNAO appreciates the guarantee that patients cannot be denied services for refusing to pay the fee, as stated in Bill 8, and we ask that this guarantee be extended to total equality of access in terms of timeliness of service and quality.

Part III, accountability: Part I was a first step in enhancing accountability. Part III addresses this issue through accountability agreements between health resource providers and the minister. The bill has been amended to explicitly exclude individual practitioners and trade unions from accountability agreements and from direct sanctions under compliance orders. Amendments also exclude collective agreements from being overridden by compliance orders. We support both of these exclusions.

Accountability is essential to a sustainable health care system, and putting teeth into the accountability provision is to be commended. It would appear, however, that accountability is a one-way street, from provider organizations to government, with no clear accountability envisioned from government to providers and the public. In particular, we would like to see that providers can expect adequate and predictable multi-year funding.

RNAO also finds weaknesses within the provider accountability clause. For example, there is no mention of the crying need for transparency for commercial enterprises like P3s, which appear to be proceeding behind a veil of corporate secrecy.

The health council could provide the necessary accountability if it is adequately resourced, with a broad enough mandate, and if it is fully independent of government. An independent council should be given the power to collect the information needed to assess key

performance issues in the health care system and to use that information to conduct key assessments such as value-for-money audits of P3 hospitals. RNAO wants to see these assessments publicly available so that all Ontarians can see what works, what doesn't, and what needs to change.

We also ask that accountability agreements and the council attend closely to two urgent nursing human resource matters: (1) monitoring progress on the government's commitment to 70% full-time employment for registered nurses, and we congratulate the government on the progress made to date; (2) monitoring progress on the government's commitment to hiring 8,000 additional nursing positions. The nursing human resources situation is dire, and accountability agreements that explicitly include these targets will ensure precious taxpayer dollars are properly used. The work of the health council could help guide the system toward a sustainable nursing workforce.

As we have stated before, we cannot speak from both sides of our mouth, saying on the one hand that we have a nursing shortage, and on the other denying full-time employment for most graduating RNs. The government took a good first step with targeted funds for full-time employment, and we expect that the May 18 budget will bring hope to the 3,090 registered nurses who have just graduated, most of whom cannot find full-time work, and many of whom are leaving the province as we speak. Government must provide funding and accountability mechanisms to ensure Ontario does not lose a single RN because of a lack of full-time employment.

Thank you. I believe we have plenty of time for questions.

The Chair: We have about five minutes left. I do want to remind all parties that we will recess in about five minutes—we have a vote we have to get to—and then we will come back. So a quick question from each, and we start with the opposition.

Mrs Witmer: Thank you very much, Ms Grinspun, for the presentation. It's really quite comprehensive and thorough. I see you've taken the time to point out where the government has done well and where there's a need for some further action.

I would agree with you; you've pointed out the need for the health council to be independent.

The other issue that I think is really critical is that this bill presently does not provide accountability for the government. How do you think the government should change the legislation to ensure that accountability goes both ways?

Ms Grinspun: I believe there should be clauses that exclusively point out the accountabilities of government, specifically in terms of stable and multi-year funding. Otherwise it will be impossible for employers, basically, to respond to the needs of Ontarians.

Ms Martel: Thank you, Doris, for being here today. You said, "We ask that the council be truly independent, with a mandate to write recommendations to the Legislative Assembly." You know that right now the only

recommendations they can make are about what else they should report on in future years. What do you foresee if we had a truly independent council that would hold government accountable? What are the kinds of recommendations this council should and could be making in that regard?

Ms Grinsepun: One of the aspects that we included is that the scope of the council should be expanded to include not only quality improvement aspects and achievements but the ongoing debate, not only in this province but in this country, in relationship to the delivery mode, specifically the issue of for-profit versus not-for-profit. We believe that unless the Health Council of Canada and any other council in the country, including the one in Ontario, deal with this specific issue, we will never resolve it and we will deal more with rhetoric than with facts. We believe that if the mandate of the council is expanded, then recommendations as to what type of services we should have in Ontario to best protect the Canada Health Act and to best provide access in a timely fashion to the public within the taxpayer dollars we have available will be appropriate.

The Chair: Mr Duguid, a very quick question.

Mr Brad Duguid (Scarborough Centre): I appreciate your comments regarding the accountability section. My question is, recognizing the need to target funding to service providers for such things as reducing the number of part-time nurses, increasing the number of nurses and improving the quality of work life for our nurses, do you really want to see those kinds of accountability agreements in the hands of a third party arbitrator who's accountable to no one? Do you not think you are better off to have the minister, who is accountable to the people who elected him, accountable to the government and committed to bringing these things forward? Do you not feel safer with regard to getting these things through?

Ms Grinsepun: You are referring to the comment of the OHA. Let me be straightforward in the answer. If the Minister of Health would always be the same person we have now, you are right, but that might not be the case, right? So to have a third party will allow us to bring issues of concern from anybody. It would be appropriate if the matter cannot be resolved at the minister's level. Today we have a minister whom we highly respect. In five years it might be a different situation.

Interjection.

Ms Grinsepun: I said the same minister.

The Chair: Thank you for your presentation, and have a good evening.

We will recess now and be back right after the vote.

The committee recessed from 1730 to 1741.

COLLEEN FLOOD

The Chair: I call the committee to order. Next we have the University of Toronto faculty of law, Colleen Flood, professor. I'd like to welcome you. Again, we'll have another vote, but I think we can certainly work

around your presentation. You will have 15 minutes; we'll divide the time at the end.

Ms Colleen Flood: First of all, I'd like to thank you for hearing my submission on this topic. Just in brief, I am a professor of health law at the University of Toronto and I'm cross-appointed into the department of health policy, management and evaluation. My work is in health law and policy, and I've written in particular about comparative health care reform, studying a number of different jurisdictions. I have written background papers for the Senate committee chaired by Senator Kirby and for the Romanow commission.

I wanted to speak today because I've seen some of the materials that have gone around in response to Bill 8, and I thought it might be helpful to have the perspective of an academic who has no particular interest in the outcome of this debate, apart from having an interest in health policy and being a taxpaying citizen and sometimes patient.

I think you've heard a great deal from those who feel threatened or concerned about Bill 8, but I just wanted to counsel you on the fact that that is to be expected: nobody likes change. But I do hope you'll agree that the surest way to suffocate medicare at the moment is not to change it at all, to deny it the oxygen of change. It's important to fix on the larger public interest that is at stake as opposed to the particular interests of stakeholders. So I want to just focus on the forest as opposed to the various trees.

There are obviously particular aspects of the bill that are of concern for different people depending on where you're coming from, but Bill 8 is primarily about injecting accountability as an operational principle into medicare. It's about other things as well, but it's to this issue of accountability and performance that I want to direct my comments.

Accountability for performance, as Romanow and Senator Kirby have told us, is what actually ails medicare. We have no idea about what we get for the billions of dollars we inject into health care. We do know, however, that we can't measure much in the returns by way of improved health outcomes. Do we know if things are really getting better or if they're getting worse? We all have opinions, but we don't have basic information, because no one in the system has the incentive to either collect or provide that information.

You might remember the famous lawn mowers case: After the Health Accord 2000 and the capital fund, the new money flowing, the only thing we know we got out of that was the purchase of some additional lawn mowers. Where did the rest of the money go? We know that it was spent on health care, but we have no idea where and for whom and on what basis of priorities that money was spent.

What do we know? We know that beyond the doors of hospitals there may be a pending crisis in safety and quality. We know that from evidence from the United States, where there are significant concerns about safety and quality within hospitals and evidence that more people die as a result of medical errors than they do in

car accidents, and there is no reason to actually think that the size of this problem is any less in Canada.

To be more specific, the crisis that we are going to face is not about more money, because obviously the US hospitals have cash beyond the wildest dreams of most Canadian hospitals; it's going to be about performance, about systems and about accountability. The crisis in health care, I submit, will not be a crisis in funding. It's not even going to be a crisis about timeliness, although timeliness is important. It's going to be a quiet crisis of quality and safety.

So we need to make sure that nurses, physicians, hospitals, long-term-care institutions, regional health authorities if we had them, and governments—decision-makers at all levels of the health care system—are accountable for what they do. We've seen tragic examples of what happens when there is no accountability or when accountability is fragmented, and then we can all point fingers at everybody else and say, "It was their responsibility, not mine." Shared accountability is just an opportunity for avoiding responsibility. We've seen it in Walkerton, we've seen it in the contamination of the blood system and we've seen it in SARS.

In publicly funded health care, there is always an assumption that the fact alone that it's public means everything is going to be hunky-dory. Most people will do the best they possibly can, but we all respond to the institutions and environments we work in, we all make mistakes and we know that with the right supports and the right vision we can do a lot better. No one in the private sector with an enterprise as large as publicly funded medicare would dream of not holding decision-makers to account for the decisions they make. Why should it be acceptable in something as valuable as medicare?

Bill 8 is a step in the right direction, even if it's just a small step. It calls for clear roles and responsibility in the management of health care. It will hold hospitals, long-term-care facilities, community care access centres and independent health facilities accountable for their performance in delivering care, and it will implement a quality council.

All these initiatives have been underway in other provinces for several years, and in other jurisdictions, like New Zealand—my original home—and the UK, for decades. The proposals in Bill 8 are hardly new and it shouldn't be controversial to ask those who receive precious public dollars to account for their performance. Accountability of, for example, hospital boards through local governance structures is good but it's not good enough. Hospitals and other institutions need to be accountable for what they do, directly to the government and through government to taxpayers, citizens and patients at large. Ontarians have a right to a system—I repeat the word "system"—of health care, not a collection of institutions and organizations forging their own paths. Bill 8 will not solve all the problems of medicare, but it's not a bad start.

To try to respond to this problem of accountability, in most jurisdictions—in fact all, apart from Ontario—there

has been a move to regionalization. The goal is that governments should govern, regional health authorities should manage, and this is a forum to integrate spending, to bring together the silos of financing.

In a separate paper that I have submitted to your committee as well, my colleague and friend Duncan Sinclair—Duncan is from Queen's University—and I advocate that Ontario, as with all other provinces, should move to regionalization.

Undoubtedly all the stakeholders who have presented to you on Bill 8 would find this even more of a horrifying prospect than the relatively mild measures proposed in Bill 8. But as we and many others have argued, regionalization is an important first step to getting governments into the business of governing and out of micromanaging health care, and to providing the means to integrate the silos of financing across our current non-system, and thus to ultimately integrate care.

In Ontario, after several decades of medicare, the general public, as the taxpayer and the single biggest funder and consumer of services, considers the provincial government of the day to be directly responsible for every problem in health care, imagined or real. Public opinion in this regard is highly conditioned by two major factors: the providers of health care and the media.

The Minister of Health and Long-Term Care and the government as a whole—I'm not just speaking about this government but previous governments as well—are in the unenviable position of being held accountable for a health care "system" that does not really exist. Among the providers of health care services, none, or at most very few, would freely acknowledge that they contribute to the collective work of a system, much less that they are accountable to the minister for the quality and quantity of their performance.

1750

The minister and government assume the role of governance only with respect to providing the money and serving as the recipient of blame when things go wrong, or not right, in the so-called system. It's an example of responsibility without authority. It is neither effective nor sustainable.

The new Liberal government of Ontario has evidenced a strong commitment to the values and principles of publicly funded health care. Early in its mandate, there is a small window of opportunity to advance a real reform agenda. Ontario has the benefit of being able to review first-hand the experiences of other provinces with regionalization.

Real change, I think, is only possible if we rearrange the present players on the chessboard of medicare. Witness primary care reform in Ontario, a process so slow and hampered that we actually think the Maple Leafs are more likely to win the Stanley Cup than primary care reform is to actually happen in Ontario. I say that, but I've still got my little flag out.

Interjection.

Ms Flood: Yes, it's been a long wait.

If the government looks at reform more broadly, reform that embraced the accountability provisions of

Bill 8 and more, it would abandon its current proposals not to go down the regionalization path and embrace it.

In the absence of devolution and regionalization, then Bill 8 and its provisions for performance agreements is a second-best alternative. The clearer and more open the lines of responsibility and accountability, the less is the risk that stakeholder interests will prevail over more diffuse public interests. Let me just be clear: That is in the best interests of the government and of providers. It is better for the government to be transparent about its objectives, as it is for providers.

Transparency is key. I think there's ample transparency provided for in Bill 8, much more than the equivalent legislative provisions in other jurisdictions, where the many checks and balances of due process do not have to be gone through before a Minister of Health can fire a CEO, for example.

I believe that everyone who has presented before you has genuflected at the altar of accountability. However, it's one thing to talk the talk; it's another thing to walk the walk. If accountability were indeed such an obvious mom-and-apple-pie concept, why have previous governments not provided for it in legislation, with or without all the caveats asked for by stakeholders? Why have stakeholders not advocated for performance agreements, or for a quality council?

Usually everyone likes the idea of accountability, except when it comes to increased accountability on their own behalves. To this extent, hospitals and other institutions are right to ask, what about the accountability of the provincial government? However, it's not the accountability of the provincial government to the hospitals, long-term-care institutions and community care access centres that is at issue. The provincial government owes accountability to the people of Ontario for governance of health care, of the health care system as a whole.

It should commit through Bill 8, I believe, to notifying Ontarians on an annual basis of what its specific short-, medium- and long-term goals are for the health care system and how it plans to achieve them. It should, in turn, negotiate and enter into agreements with hospitals, long-term-care institutions, community care access centres and other groups for the realization of these objectives. The health quality council should report on the realization thereof, with, as is provided in Bill 8, the report being tabled in Parliament.

I agree with those who call upon the provincial government to address issues of timeliness in treatment, but I do not think it needs to happen through the auspices of Bill 8 at this time, for it cannot be done overnight. Instead, I think it should charge the health quality council to work toward setting appropriate maximum waiting times for a variety of disease indicators and then incrementally include realization of those waiting time guarantees and performance agreements with hospitals and other institutions.

Undoubtedly, this may take additional resources, but I am confident that those who are asked to achieve change will make their need for resources known.

Change is extremely hard to realize in publicly funded health care, but we must recognize the only way to save medicare is to change it. The enormous forces of resistance to any real change may well continue to prevail, arguing that change is not possible because we don't have enough money to fund the core—the core of hospital and physician services.

This is a vicious circle, because unless we begin to invest in other areas of care, like community care and primary care, the same old problems will continue on and on. We can placate with money, but the status quo will not change and real reform will not occur. Ontario now has the opportunity to convert its rhetoric about renewal into action through Bill 8. Let's seize it.

The Chair: Thank you very much. Perhaps one short question. Actually, when I look at my watch, we're down to the wire. Thank you very much.

Ms Flood: OK. Sorry I took so much time.

The Chair: We really appreciate your presentation, and I wish you a good evening.

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

The Chair: Next we have the College of Physicians and Surgeons of Ontario. Please make yourselves comfortable at the table.

Interjection.

Dr Barry Adams: Do you want to adjourn and go to the vote, and we can present after the vote?

The Chair: We have about six minutes that we could get part of your presentation in, if you don't mind splitting your presentation.

Welcome. State your name when you present so we can have it on the record for Hansard.

Dr Adams: Thank you, Mr Chair and members of the committee. On behalf of the College of Physicians and Surgeons of Ontario, I want to thank you for this opportunity to present. I'm sure you're aware we were here before. We certainly have an interest in this issue and want to bring you up to date on our interests.

My name is Barry Adams. I'm president of the college. I have been a practising paediatrician in Ottawa for the last 39 years. I continue to practise because there are no new doctors out there to replace me. With me are Rocco Gerace, the registrar for the college, and Louise Verity, the director of communications and government relations.

The government maintains that the principles of accessibility and accountability are the key drivers behind the introduction of Bill 8. The college supports both of these principles.

Our presentation today is focused exclusively on section 16 of the bill, the section that deals with block fees. The college continues to have concerns with this section of the bill, as it allows for the transfer of block fee regulation from the college to the Ministry of Health. As the legislation is currently drafted, anyone who charges a block fee that is not in accordance with the

regulations will have contravened the legislation and committed an offence. That presumably would be prosecuted under the Provincial Offences Act. The college does not normally instigate proceedings under the Provincial Offences Act.

As it stands currently, the CPSO block fee policy is enforced by the college through a policy as opposed to a regulation. As with all college policies, this policy is reviewed every three years to ensure that, amongst other criteria, the policy meets its intended objectives and is in the public interest. The college does not have to contend with the volume and nature of policy issues that government faces and that sometimes prevent government from moving as quickly as it should. We believe that the college's mandatory review process ensures that changes and improvements are made in a timely manner.

At the very least, we recommend that any block fee policy or regulation should include a mandatory review component to ensure it remains current.

We have found, over the years, that the government has often either been very slow in implementing regulations that we have submitted, or been so extremely slow that our regulations are often so out of date that they require us to revise them before they can be implemented. Many other colleges have had similar experiences. This is in large part why we believe our policy development and review process to be more responsive to the public interest. Our processes provide for a mandatory review and consultation, as well as an expeditious approval process.

We heard shortly after the introduction of Bill 8 that the ministry has received some calls from the public about our current block fee policy. To date, the context of these calls and volume of these concerns have not been shared with us.

As we conveyed to the committee previously in our initial presentation, our block fee policy is currently undergoing a review. This review was initiated prior to the introduction of the bill. The college has persevered with this review despite the uncertainty about our future role with respect to block fees.

I'd like to take a few moments to explain our policy to you. The current block fee policy allows doctors to charge their patients for services that are not covered by OHIP. Uninsured services include telephone advice, requests for renewal of prescriptions by telephone, the completion of forms etc. The services covered by this fee must be clearly stated in writing and understood by the patient, and the patient must be given the option of paying individual charges for uninsured services as they are rendered or by paying an annual block fee.

The decision as to which payment option is chosen must be made by the patient and must not be a condition of the patient being accepted by the doctor or continuing under the care of that doctor. The patient must be given a copy of the block fee policy statement and indicate his or her acceptance of paying for uninsured services in this manner before being billed a block fee. A fee for the service of "being available to render a service" cannot be

charged in advance and is not to be included in a block fee.

You should be aware that it is the Ontario Medical Association and not the college that is responsible for establishing guidelines for actual block fee charges. We have been in discussion with the association and they agree that block fee charges should be made available to the public when requested.

The college has identified key areas of improvement to the existing policy to ensure that it is transparent, accountable and clearly distinguished from extra-billing. A block fee is a charge for an uninsured service only; it is not a premium paid to a particular physician for any services rendered. In addition to our consultation process, the college is also reviewing policies from other jurisdictions such as Alberta, New Brunswick, British Columbia and Manitoba. These policies are in the process of being assessed as part of our block fee review.

The block fee policy has been available on the college's Web site since 1997, and the May-June issue of Members' Dialogue, which is a communication that goes out from the college to all physicians in the province, clarified the current block fee policy.

The college takes our role in educating the profession very seriously to ensure our policies are clear to Ontario physicians. We also take the necessary action to ensure our policies are effectively enforced.

In 2003 there was a prominent example of a physician inappropriately charging patients for services and disguising these as block fees. The college's discipline committee investigated the complaints and found the physician to be guilty of professional misconduct. In response, the physician's certificate of registration was suspended for a period of three months and he was required to reimburse all patients for any inappropriate charges.

The Chair: My apologies for interrupting at this moment, but we will have to recess. You have about six minutes, so we'll come back and continue for another six minutes.

Dr Adams: That's fine.

The Chair: We won't be long.

The committee recessed from 1804 to 1812.

The Chair: Ladies and gentlemen, I'd like to call our committee hearings to order. We'll have six more minutes from the College of Physicians and Surgeons.

Dr Adams: I was just saying that we take our responsibility quite seriously, and when we are aware of a breach in policy, we certainly do investigate it and, if necessary, take action. The college hopes this shared goal to protect the public can be achieved while respecting the autonomy of the college to administer this function.

The college would also like to ensure that the consultation process we have underway will continue. The college anticipates that our recommendations and the new policy developed as a result of our review will be incorporated in any regulation created by the government if a decision is made not to amend the legislation and leave it as it is, under the aegis of the college.

In conclusion, I'd like to thank you again for the opportunity to provide input to the drafting of this legislation. The college welcomes a continued open dialogue with the government as recommendations are considered and amendments are drafted and finalized.

It is our hope that the government will amend the bill in a way that will achieve the following: Regulation of block fees remains a responsibility of the College of Physicians and Surgeons and is within a statute that governs the activities of the college, like the Regulated Health Professions Act and the companion legislation, the Medicine Act. We also would like that block fees remain a policy as opposed to a regulation.

Finally, should the government decide not to amend the bill, it is our hope that the college's work in reviewing and improving the block fee policy will form the basis for a block fee regulation.

The Chair: Thank you for your presentation, and our apologies for the break in your presentation.

We have enough time for one quick question from each party. We'll start with Ms Martel.

Ms Martel: You said your review is ongoing and that if there's no change in the legislation, you would offer up the results of that to be part of the regulation. Can you share with the committee at this time any of the information coming out of that, which might be helpful to the process?

Dr Rocco Gerace: We're very early in the process, and we're trying to get feedback from all the stakeholders who are involved. This is a periodic review, and we're not at that stage. We're very anxious that we be able to continue the review and that we be able to get feedback from government, patient groups and others.

Louise may want to make a comment as well.

The Chair: Very quickly.

Ms Louise Verity: I think one of the reasons we're so eager to get feedback from the ministry is that we are culling any telephone calls, any type of inquiry we have received. We want to know about any that anyone else has received so we can put that into the mix, in terms of coming up with recommendations.

Ms Smith: I have a question with respect to the communication of your policy. I recently spoke to a family doctor—just a casual conversation—and asked about block fees. That doctor told me she was planning on implementing a block fee program—\$100 a patient—and

didn't even bat an eyelash that this could be unacceptable or against college policy. She just said, "Yeah, I'm looking at implementing a \$100 fee, because I can't manage all these little nickel-and-dime fees everywhere." I said, "Are you going to do that for all your patients?" She said, "Yeah. I mean, I can't figure out who's in and who's out." I said, "Well, could I just recommend that that's not appropriate?"

That just smacked to me of exactly what we're trying to deal with in this legislation, which is ensuring accessibility. To her, a \$100 block fee was nothing. To many members of our society, a \$100 block fee is prohibitive. So I just wondered how the college communicates and then polices or enforces its policies with respect to block fees now.

The Chair: A very quick answer. We have about half a minute.

Dr Adams: Actually, as I said, last year we put an article in our Members' Dialogue about how to let your patients know about block fees and what they entail. We can't ensure that everybody reads the Dialogue, but hopefully they do. If a question came up from any of her patients about the way she implemented a block fee, we certainly would look into it through our complaints process.

Mrs Witmer: Thank you very much for your presentation. I'm pleased to see that you have initiated a review and a consultation yourself of the policies in other jurisdictions. It looks to me that you've given an example here where you did take action when you found there was inappropriate use, and I congratulate you on that.

What is it now that you want from the government? Do you simply want them to amend the bill to allow you to continue to do what you've been doing?

Dr Adams: That's what we would prefer, and if that doesn't come about, we certainly would like to have input into the regulation and how they expect it to be enforced—if not under the health protection act, under which act would it be?

The Chair: Thank you for your presentation this afternoon. I wish you all a good evening.

I would like to thank the committee for your patience with me. This committee stands adjourned until 4 o'clock tomorrow.

The committee adjourned at 1818.

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First Session, 38th Parliament

Official Report of Debates (Hansard)

Tuesday 4 May 2004

Standing committee on
justice and social policy

Commitment to the Future
of Medicare Act, 2004

Chair: Jim Brownell
Clerk: Susan Sourial

Assemblée législative de l'Ontario

Première session, 38^e législature

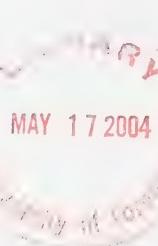
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Comité permanent de la
justice et des affaires sociales

Loi de 2004 sur l'engagement
d'assurer l'avenir
de l'assurance-santé

Président : Jim Brownell
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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON
JUSTICE AND SOCIAL POLICY

Tuesday 4 May 2004

*The committee met at 1601 in committee room 1.*COMMITMENT TO THE FUTURE
OF MEDICARE ACT, 2004
LOI DE 2004 SUR L'ENGAGEMENT
D'ASSURER L'AVENIR
DE L'ASSURANCE-SANTÉ

Consideration of Bill 8, An Act to establish the Ontario Health Quality Council, to enact new legislation concerning health service accessibility and repeal the Health Care Accessibility Act, to provide for accountability in the health service sector, and to amend the Health Insurance Act / Projet de loi 8, Loi créant le Conseil ontarien de la qualité des services de santé, édictant une nouvelle loi relative à l'accessibilité aux services de santé et abrogeant la Loi sur l'accessibilité aux services de santé, prévoyant l'imputabilité du secteur des services de santé et modifiant la Loi sur l'assurance-santé.

The Chair (Mr Jim Brownell): I'd like to call the committee meeting to order. I'd like to welcome one and all, committee members and the deputants, to the hearing this afternoon. Just a bit of housekeeping: Number 12 of the "Summary of Decisions Made at the Subcommittee on Committee Business" says, "That the committee meet on May 17, 18, and, if required, May 31, 2004, for clause-by-clause consideration." May 18 is budget day and I'm wondering if there would be consensus around the table to have the committee meet on the 17th and 31st only. Any comments on that?

Mr Frank Klees (Oak Ridges): Sorry, I was on the phone.

The Chair: I was just indicating that the 18th is budget day and—

Mr Klees: I understand, but what is the purpose for our meeting on those three days?

The Chair: Clause-by-clause consideration.

Mr Klees: The clause-by-clause? So you're going to back it down from three days to two?

The Chair: I'm just wondering if because of that date—

Interjection.

The Chair: OK. Yes, the 17th and 18th were the two days, and if required, May 31 would have been the third day.

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

COMITÉ PERMANENT DE LA JUSTICE
ET DES AFFAIRES SOCIALES

Mardi 4 mai 2004

Mr Klees: Now you say the 17th and the 31st and, if required, another day.

The Chair: Is that satisfactory? Very good. We will change that. I just wanted you to understand that this was in the summary of decisions at that subcommittee. So we'll say the 17th and 31st. We'll have another day if it's required.

All in favour? OK, very good.

CANADIAN UNION OF PUBLIC EMPLOYEES,
ONTARIO DIVISION
ONTARIO COUNCIL OF HOSPITAL UNIONS

The Chair: I'd like to welcome the Canadian Union of Public Employees, Ontario division, and the Ontario Council of Hospital Unions. Please come up to the table. Make yourself comfortable. Please state your name at the beginning of your presentation so that Hansard has a record of that.

You'll have 15 minutes. If you don't use the full time, we'll have questions from the three parties. We'll start with the official opposition and go in that order. I want to make it very clear to the committee that should we get done and there's just time for one, then we will start with the next in line. I'll make it fair, that if we get to that situation again, we'll have the next party.

Mr Michael Hurley: Thank you very much, Mr Chair and members of the committee, for allowing us to make a presentation today. My name is Michael Hurley and I'm the first vice-president of CUPE Ontario. With me today is Doug Allan, senior research officer for the Canadian Union of Public Employees.

Just as we begin, I'd like to thank the committee for the amendments that were made on March 9, which had the effect, we believe, of addressing concerns that our union, among others, had raised around the vulnerability of collective agreements to being moderated. We appreciate that those amendments were introduced. But we have outstanding concerns and I'd like to deal with those today, if possible.

First of all, in terms of why we are concerned, before the last provincial election the Liberal Party of Ontario promised to put the for-profit MRI and CT scan clinics into public hands. The party also promised to stop public-private partnership hospitals. Those promises helped, I believe, to secure for the Liberal Party the support of the Ontario voters.

Unfortunately, the government has, it appears, reneged on both of those commitments. There is no sign that we will move the seven for-profit MRI and CAT scan clinics into the public sector any time soon. The two P3 hospitals that the Conservative government proposed appear to have been given the go-ahead, and we also understand that a number of hospitals—as many as 10—have been given green lights to explore P3 project development. The Ministry of Public Infrastructure Renewal is conducting a review, looking at expanding P3s throughout the hospital sector as the form of redevelopment there.

When Bill 8 was introduced in late November 2003, the Ministry of Health and Long-Term Care claimed it would “put an end to the creeping privatization of the system in recent years.” As we have mentioned to you in earlier appearances, we believe Bill 8 does no such thing. It will not impair privatized hospitals or for-profit clinics. Indeed, for reasons unknown to us, the bill as originally written could have been interpreted so as to override collective agreements, and those concerns have been addressed.

In our previous submission to this committee, we noted our concerns about the sweeping powers this bill confers upon the Minister of Health and Long-Term Care to restructure and reorganize health care. These powers could be used for health care reorganization; for example, the consolidation and privatization of laundries, laboratories, dietary departments and other services. In fact, the consolidation and privatization of many of those services has begun.

There are troubling signs that there is an increased focus on attacking health care support and administrative services. The ministry has made it clear that they expect hospitals to eliminate deficits—deficits that hospitals have been forced to run due to underfunding. Since this demand for balanced budgets was put forward, most of the focus has been on cost savings that can be squeezed out of hospital support services.

There are troubling similarities between the accountability and performance agreements in Bill 8 and the health care performance agreements adopted by the British Columbia Liberal government. Both tie the compensation of the chief executive officers of health authorities to the goals in the agreements. The most specific and concrete target in all of the BC agreements is a reduction in spending on support and administrative services. As you know, this year’s performance agreement for British Columbia requires a 7% budget reduction for support services. Since the BC agreements, we have seen a heavy emphasis on privatization, layoffs and reductions in these services, and certainly that’s highly topical lately.

The Daily News of Kamloops notes, “Chief executive officers of BC’s six health authorities will pocket fat bonuses if they make cuts that surpass criteria set out by the provincial government.” This from the same government that has forced 15% wage cuts on health support workers, primarily women.

In Ontario on May 7, the Ontario Hospital Association will sponsor a conference on integration of support

services. The OHA has announced that it will establish a task force on efficiency and integration. The task force is being developed in partnership with the Ministry of Health and Long-Term Care.

The focus on support services is ironic. As we noted in our previous brief, this is the portion of hospital spending that has consistently reduced costs and cut staff, and yet it is vital for adequate infection control in hospitals and health care facilities, an obvious emerging issue.

With respect to the real costs that are driving up health care spending, we haven’t seen any evidence—and certainly nothing in this bill—that would hold drug companies to account for the huge hikes that have happened in the cost of drugs, something that has cost the Ontario treasury and the Ministry of Health and Long-Term Care huge increases in a relatively short space of time: 200% in six years. Nothing is holding those parties to account for that.

We do not see any effort to rein in unnecessary costs like those lavished on consultants, lawyers and managers by hospitals that refuse to participate in the central bargaining process, even though central bargaining is adequately funded by the provincial government and supported by most hospitals in the province.

We have proposed that there should be one single joint benefits plan for all health care facilities in Ontario, a concept supported by all of the major unions in health care in Ontario. We have no take-up on that concept from the Ministry of Health and Long-Term Care. With respect to doctors’ compensation, we haven’t heard any measures to deal with the inefficient fee-for-service billing system.

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But most significant is the fact that the P3 hospitals are pushing forward. As you know, the cost overruns on the Brampton project—the construction costs in Brampton are now double what they were originally projected to be. The cost of borrowing is now projected to be \$56 million more than if the project had been constructed in the normal way through public financing. We’ll soon be extrapolating those costs across the entire hospital system, but trust it to say that they’re entirely consistent with the huge cost overruns that were experienced in Britain, and we expect we’ll see that same dynamic here. We’re going to see the cost of these projects soar, and they will make the savings the government is seeking to achieve through its so-called efficiencies appear relatively insignificant in the big scheme of things.

Here we have a government that said it would not go ahead with P3 hospitals approving two that the previous government approved, and it looks like they’re going to green-light another 10 and the ministry has now endorsed that as the model for redevelopment for all the hospitals.

We know there will be huge cost overruns. We know the borrowing costs will be hugely more significant than they would have been if it had been done in the normal way. We know the consequences of that will be staff reductions of around 25% overall, including 14% fewer

nurses and 38% fewer support staff. We also know we're going to see bed reductions in the neighbourhood of 30%. Everything that's folding out in Brampton is entirely consistent with what happened in Britain. The same advisers from Britain have been imported to give advice to the Liberal caucus and cabinet, so it should come as no surprise.

In this area, though, the government is not being held accountable to the people of Ontario. Although commitments were made, in the face of scientific evidence that that was bad policy, was inefficient, would lead to a huge downsizing in acute care beds, a huge downsizing in staffing and be way more expensive and that taxes would have to be increased in the future to make up for it, there's no accountability in that respect. We're very concerned about that, and we're very concerned that the emphasis on restructuring in health care is going to be, as it is in British Columbia, all about making sure that the women who deliver services like cleaning, who are already stressed—

Interruption.

The Chair: Sorry about that.

Mr Hurley: I think the thrust of policy here is to make sure that hospitals and other health care facilities can be coerced into making the kinds of changes that have happened in British Columbia through reductions to budgets, coercing managers to privatize services, to reduce costs, which means women will be driven into poverty. It means the next time that SARS emerges in Ontario and there are way fewer cleaners making \$9 an hour and they have no pensions and want to go to work for somebody who will pay them \$10 or \$11 an hour, we'll see the benefits of that policy.

I have to ask you, in terms of accountability, how it can be that the government can apply such screws on institutions to achieve savings from support services and ignore the huge cost overruns that are occurring already and that are bound to occur through the P3 policy?

In conclusion, we would encourage the committee to radically rethink the accountability sections of this bill. One thing that's missing from health care in Ontario is true community involvement in health care decision-making, and certainly this kind of centralized health care planning that is driven from Toronto out into the regions is not going to facilitate democracy and community involvement. We'd ask you to rethink that and to limit the minister's power around accountability provisions and compliance directives. We'd ask you also to ensure that you, as a government, are accountable to the people of Ontario by delivering on the commitments you made with respect to P3 hospitals and private MRI-CAT scan clinics, which are hugely significant expenditures in the grand scheme of things.

Sorry to tirade you.

The Chair: We have three minutes remaining. Perhaps each party will have time for one very quick question.

Mr Klees: I rather enjoyed the tirade, and I hope the members are listening very carefully. A lot of promises

that were made were broken. This is just one of them, but it obviously impacts you very much.

With regard to the sweeping powers you refer to that are still left in this legislation, I agree with you on that point. At least when health care reorganization or restructuring takes place now, it has to be initiated by the administration and approved by a community board that currently is empowered. What this legislation does is take that authority away from the community board and local administration and rest it with the minister. Can I ask if you have a specific amendment you would propose to deal with this accountability issue?

Mr Hurley: We'd like to see the accountability provisions withdrawn and rethought through a process of true consultation with the many people who are involved, either as citizens, as caregivers personally, as people who work in the system, or as people who care about it in terms of what a truly accountable health care system would look like. We'd like a process, really.

Ms Shelley Martel (Nickel Belt): I just want to focus on the P3s and the public-private MRIs, because as I see it, money that should be going into patient care ends up going into the pockets of for-profit providers. I'm particularly concerned about the P3 hospitals, because significant amounts of money will have to come out of the operating budgets of hospitals to pay what essentially is a mortgage. Where do you see that going when the hospital is forced to use operating dollars that should go to patient care to pay off what essentially is a capital cost, ie a mortgage?

Mr Hurley: It's no shock to anybody in this room that hospitals are already operating on the line. Our accountants estimate that it's going to cost an extra 14% on the borrowing, and an extra 15% to 25% a year would be the profit surcharge, according to the British Medical Association Journal. That money is going to come out of operating budgets, and that's going to cause downsizing of both staffing and beds at a time when the Ontario population is aging, growing and demanding more acute care services. So we're going to lurch into crisis. Britian addressed it, as you know, Ms Martel. They were forced to introduce extra taxes to make up for the shortfalls and the money flowing out of the system.

The Chair: A quick question, Mr Leal.

Mr Jeff Leal (Peterborough): I'll make it quick. Mr Hurley, I'll give you a real-life situation. Down in Belleville, money was provided to the hospital to hire nurses or other front-line staff. One of the reasons I think the accountability agreements are necessary is in order that we would make sure hospitals take that money and hire the front-line staff we need. I just want your comments: Instead of hiring front-line staff, they gave a 10% raise to their senior administrators. That's why I think these accountability agreements are needed, to make sure that money is allocated to hire your people. This is what happens.

Mr Hurley: There's no question that hospitals are not very democratic institutions.

Interruption.

The Chair: Don't worry about it. Keep going, sir.

Mr Hurley: With respect, how would you get institutions to conform to directions that were seen as being socially appropriate or important; in this case, hiring more nurses? There's got to be a process that involves people in the community being involved in that institution and having some ability to give it direction. Hiring more nurses is not only thought to be positive by the Ontario government; many citizens would agree with you there.

The Chair: We have run out of time. I would like to thank you for your presentation. I wish you a good afternoon.

Mr Hurley: Thank you.

1620

ONTARIO PUBLIC SERVICE EMPLOYEES UNION, LOCAL 348

The Chair: Next we have the Ontario Public Service Employees Union, Local 348, Lakeridge Health Corp. Welcome. As I said to the last deputants, you will have a 15-minute time period to use as you wish: if you want to use it for the full time of your presentation or we will have questions after. Also, make sure that you state your name for Hansard.

Ms Patty Rout: Thank you. My name is Patty Rout. I'm the chair of the OPSEU health care professionals. I have several chairs with me from the different divisions of health care in this province, of which we make up 29,000 people. To my left is Tony Morabito; he's the chair of mental health. To my right is Sue McSheffrey from community care. We also have Jamie Ramage from ambulance, Debbie MacDonald from long-term care and Jill McIlwraith from support hospital care.

I want to thank you again for allowing us to make this presentation. I was here maybe a month or so ago and didn't actually have an opportunity to have questions presented to us, so I'm hoping there'll be time for that today. We wanted to have the opportunity to talk with the committee once more about the challenges that face the workers in the health care system, to reinforce our concerns about what is happening in our health care sector and to talk about what a real commitment to medicare would mean.

The past round of hearings with respect to Bill 8 led to government amendments that dealt with our concerns about the power of government to open and change collective agreements. But this government has not dealt with P3s and it has not dealt with the MRI-CT situation, and this government promised that they would.

Bill 8 gave the Minister of Health broad powers without any form of democratic control and the right to order fundamental changes in our health care system with little or no public consultation, procedural safeguards, transparency or other checks and balances. Bill 8 essentially paves a legal path for the government to restructure Ontario hospitals through privatization, cost containment and the contracting out of services. Ministerial power can

be used to force hospitals to reduce or consolidate services or to contract out health care services to private companies, and that's why we are afraid of Bill 8. It has little concrete initiative to protect the principles of the Canada Health Act or enhance medicare, despite its title.

Still missing from the bill are the following: concrete initiatives to apply the principles of the Canada Health Act; a prohibition on P3s and the return of private diagnostic clinics to hospitals to stop privatization; a health council that is an objective body with a democratic appointment process; the prohibition of for-profit providers; a requirement to report and make recommendations on how the health system meets the principles of the Canada Health Act; and the provision for accountability of health institutions and the health minister to the people of Ontario, which would include democratic control, meaningful public input and consultation, transparency and disclosure and whistle-blower protection.

We want to see a stop to the queue-jumping for so-called medically unnecessary procedures and to stop the fees and charges and the erosions that are due to delisting. We would like to see a stop to block fees, the boutique medicine and the extra billing, and support for progressive primary care reform. We want a stop to the delisting of medically necessary services and the relisting of those that have been removed, and a comprehensive range of medically necessary services to meet the population need, as per the Canada Health Act.

I would like to say a few words about the shortage in recruitment and retention. I'm a medical technologist, and there are very few of us left in this province. We are becoming kind of extinct. We have been unable to get people to come in to our profession for various reasons. This government recently announced lots of money for nurses, but not a lot of money for the rest of the health professionals who belong in this province, and it upset many of the professionals I work with. We would like to see this government address those people who are just as important to the health care system as doctors and nurses.

I'd like to open up for any questions at this point.

The Chair: OK. We have about six minutes—actually, seven. We will start with the third party.

Ms Martel: Thank you for being here again today. I've seen some of you before.

You are right to be worried about the compliance directives, because those can be unilaterally imposed by the minister, and it is very clear that those could be used to force the amalgamation or the contracting out of services, getting at jobs from some of your members in a backhanded way, so you should be worried about that.

I wanted, however, to focus on privatization, because you made it very clear that the bill should prohibit P3 hospitals; the bill should guarantee the return of MRIs and CAT scans now in the private system to public hospitals like the government promised they would before the election.

What is it that concerns you about privatization of health care services?

Ms Rout: Especially in the MRI-CT area, I have watched, with experience from my particular hospitals, where MRI techs have been pulled out of the hospital system to go into the private sector. They've been offered great deals of money to do that; they have better shifts, they have better weekends. Consequently, what has happened in our particular hospital and others: The lines have become longer in the hospitals.

The travesty of it is that people who have to come to the hospital for an MRI because they may have a brain tumour are in a longer line now than they ever were before. You cannot be done in a private clinic; you have to go to a hospital to have it done. So people who break their leg, or feel they might have broken their leg, and demand that they have an MRI go to a private clinic and get it the next day, and the person who has the brain tumour, whom you'd like to get treatment for as quickly as possible, has to wait six to eight weeks in order to get an MRI. I'm particularly afraid of that.

We're very concerned that there's to be privatization of labs. Right now there's a huge reform going on that seems to be built around Bill 8. We have had many presentations made to us about how it costs less to do services in the private sector, but there are many indications across the country that that's not true and that it actually costs more money, so why would you even look at a system like that?

Ms Sue McSheffrey: I work in community care. I met you in Ottawa, actually. This is my trip to Toronto. That's still a concern of mine. It's my specialty; I am a physiotherapist. I've seen that we've given less service for a lot more money since the system got privatized. And there's less accountability, because those private corporations are not subject to the same disclosure rules as the public sector. So you can't get information about what the profit margins are, what the cost of doing these RFPs is and even if there are extra costs going into wining and dining to get those contracts.

Mr Ted McMeekin (Ancaster-Dundas-Flamborough-Aldershot): I'm intrigued by your presentation. Just by way of background, I have been involved in health care for many years on a district health care council. My spouse is a medical doctor working in a community-based, multidisciplinary clinic and I'm fascinated with the whole area of primary care reform. It has not been taken up; I think 4% of the doctors have signed on to the voluntary route.

Let me ask you very directly, because I have a bias here, how you would respond to a government initiative that would see preferential funding provided to community-based, multidisciplinary, front-line health care service. If we had a choice between funding options and we decided to be preferential in our approach to actually provide greater funding for those who buy into that model, how would you react if the government were to take that kind of policy initiative?

1630

Ms McSheffrey: For myself, as a community health care worker at the primary care end, I think it would

make a lot of sense. It's where you get the best bang for the buck, particularly around family medicine. This move toward having no family physician and going into small hospital emergency departments to see a doctor is very wasteful, and so is not having a doctor, because you have this sort of shopping around: "Well, he didn't say the right thing; I'll go somewhere else"—the whole part of consumer education around health care and the fact that with best practices maybe what happened 10 years ago isn't the best treatment now for that particular disorder. Personally, I think it's a very good way to go.

Mr McMeekin: So you would favour that kind of approach.

Ms Rout: Yes, I would agree.

Ms McSheffrey: Yes.

Mr McMeekin: I appreciate that. That's very helpful, because we've got some difficult choices to make, and that may be one of them.

Mr Klees: Thank you very much for your presentation. Do you feel let down by this government after all the expectations that they raised with you in terms of doing away with P3s and doing away—in fact, I just did an interview this morning with our local media. The local member was very strong on condemning the private MRIs in York region, for example, and the fact that they're still there. It's very obvious that the government has changed its position on that.

As front-line workers and as an entire profession, no doubt this was a key for you in terms of lending your support to this political party. Perhaps your profession was, because of—you say you have some 20,000 across the province?

Ms McSheffrey: Some 29,000.

Mr Klees: That's pretty substantial. When you take a look at the various ridings, in a number of ridings there is only one with 500 or 1,000 votes. Your profession may well have made the big difference between these folks being in government or not. Yet you've been betrayed on this issue. Is that how you feel? I'd just be interested in your thoughts on that.

Ms Rout: Yes, we definitely do. It's probably the first time I can recall that our members have gotten behind something during an election. They very clearly wanted to see MRIs and CTs stay in the public system. I don't think contractors should decide who's going to get the health care and who isn't, and we don't think they should be able to pay \$300 or \$400 more to somebody so that they can put it in their pocket rather than putting it in the system.

The other thing is, we have such huge shortages, that has just made the shortage worse. At work, it has made the line longer; it has made more complaints. It's difficult. It's like an assembly line—if anyone has been to an MRI room. This government said they would look after it. They promised it and they haven't done it. On a P3 level—

The Chair: Very quickly. We have half a minute.

Ms McSheffrey: OK. I just wanted to say that the feeling of betrayal is the worst thing of all, because we really believed that this government would make a

change. It has added to this distrust of government in general and elected officials, which is outrageous. You were elected on something that you said you would do. You have to do it; you really do.

The Chair: Thank you very much. We've come to the end of the 15 minutes. I would like to thank you for your presentation and wish you all a good afternoon.

MARC SIMBROW

The Chair: Next we have Marc Simbrow. I'd like to welcome you. As I indicated at the beginning, you will have 10 minutes for your presentation. If you do not use the full time for your presentation, we will have questions, and we will be starting with the government side. So you have 10 minutes.

Mr Marc Simbrow: Yes, sir. My name is Marc Simbrow. I would like to thank you for inviting me back again to address Bill 8. It is an honour, once again, to participate in open government. We have an equal health care system here in the province of Ontario, which is vital to every Ontarian.

I would like to ask all honourable members to thank every nurse here in the province, as today is nurses' day. Of course, with their hard dedication, that is something that we should never forget about.

Excuse me for coughing. My hay fever isn't fun.

As I was saying, where would we be without them? The nurses work so hard. Physiotherapists facilitate a faster recovery period; they help speed up the recovery period. I feel that they should remain on OHIP. Physiotherapists help your hands, your back and everything else. They help in conditioning those who really need it. Without physiotherapists, if you're injured, then it would be very hard to recover from this.

I have been following the debate very carefully, and there's one thing I must say. I have heard the nurses talking positively about health care and that change is coming for the better; they want to work. However, there is fearmongering going around. This must not happen, because if it does, then we'll get the nurses scared, we'll get the doctors scared, we'll get the public scared. That is not Ontario.

I'm sure that we all have different ideas on how health care should be run. That's fine, but fearmongering must not take place. If it does, then this is going to hurt the public; it will hurt the nurses, the doctors. What would happen if the nurses started looking toward the USA? A lot of them have stopped going to the USA, saying, "I want to stay in Ontario."

I also gave all honourable members—I picked this up on my computer the other day. It's called the Canadian Physiotherapy Association mobility quiz, which I gave to every honourable member.

I would like to thank you kindly for inviting me to speak to all the honourable members.

1640

The Chair: Thank you very much. We have four minutes remaining. We'll split the time, starting with the government side.

Ms Monique M. Smith (Nipissing): I'd like to thank you very much for coming today and for presenting to us. Thank you for the handouts you've provided, but we don't have any questions this afternoon.

The Chair: OK. We have the official opposition.

Mr Klees: Thank you very much for coming. I will do the quiz. What do I do with it when I'm done? Is there a score here?

Mr Simbrow: Yes, Mr Klees, there is. One is, of course, for the females and one is for the males. If you take a look on—let's see.

Mr Klees: Maybe while you're looking, I'll figure out which one is mine. But you say here—

Mr Simbrow: Here we go. If you—

The Chair: Half a minute on this. That's what's remaining.

Mr Simbrow: Mr Klees, right toward the end, there should be four pages. You're going to see number 4 to number 9. That will say "bending," "kneeling" or "stooping."

Mr Klees: Yes, I see that.

Mr Simbrow: Then right under that, you add your score.

Mr Klees: OK. Thank you very much.

Ms Martel: This is the second time that you've come to visit us, so I don't have any questions but I do want to thank you for taking the time to come and participate in the public hearings.

Mr Simbrow: Thank you, Ms Martel.

The Chair: Thank you for your presentation this afternoon. On behalf of the committee, I would like to wish you a good afternoon.

Mr Klees: Chair, while the next person is coming up, I think every member should do this quiz and submit their scores to you for grading, just so we know where we all stand on the mobility scale.

Mr Simbrow: Excuse me, Mr Chairman. Would it be possible if Premier McGuinty could have a copy? Maybe he would like to just fill one out.

The Chair: I'm sure we could get a copy to him. Thank you.

Mr Simbrow: Thank you kindly.

ONTARIO HEALTH COALITION

The Chair: Next we have the Ontario Health Coalition. I'd like to welcome you to the hearings this afternoon. As with the other organizations, you will have 15 minutes to make your presentation. Should you not use all the time, we will split the time between the parties. Welcome.

Ms Natalie Mehra: Thanks. I think you have our written submission, which includes who we are, so I won't go into that.

I wanted to start off by saying that we applaud several of the changes that you've made. The one that is important, we think, is the inclusion of the mention of public interest and the changing of "consumer" to "individual," which is symbolic but important. However,

we do have some serious problems that I'd like to draw to your attention, both with the process and the content of this bill as it has been amended.

The first is that on behalf of our membership across the province, this particular set of hearings, which is geographically located in Toronto and very short, really doesn't give them equal access to input this round. So I want to draw that to your attention and hope that you could find a way to open up the process and include people from other areas.

Also, the changes to the bill really seem to reflect the interests of a fairly narrow set of interests, specifically the Ontario Hospital Association. You can see that that's in there, that the Ontario Medical Association's interests are in there, but really, the recommendations made on behalf of patients' interests haven't made it into the amendments of the bill. So I'm going to reiterate at least the key concerns we had regarding the public interest and patients' interests in the hopes that you will hear them this time around.

The bill, in its original form and as in the amended version, actually does not provide any concrete initiatives to protect or enhance the application of the principles of the Canada Health Act. We believe that a bill titled Commitment to the Future of Medicare ought to protect, at least—and certainly, we would hope, enhance—the principles of the Canada Health Act. It provides no concrete initiative to protect or enhance accountability to the users of the health system. I'm not talking about the health system to the minister, but the minister and health providers to patients and the public. It provides no concrete initiative to stop the erosions and challenges to medicare with respect to privatization, specifically two-tier access for so-called medically unnecessary services, increased fees and privatization. As such, we believe the title, Commitment to the Future of Medicare, is unfounded and so are the commitments made in the preamble, although we support them.

Specifically, the government committed to an independent health council. In our original submission, we made some recommendations regarding a process that had both the appearance and the substance of objectivity in the appointment of that health council. We think it's a mistake for the government to be appointing the health council, that there will be the potential for that health council to be viewed as simply political appointees. We think it's important that the health council be seen as objective, and we reiterate our suggestion that you consider something like a tripartite appointment process or some other democratic process for the appointment of the people on the health council.

We also recommended that the health council specifically exclude those people who have a financial interest in a for-profit health corporation or are executives in for-profit health corporations. We see that in the amendments you have excluded executives and board members from not-for-profit hospitals; from for-profit hospitals; from long-term-care facilities, both for-profit public and not-for-profit; and several other types of not-

for-profit agencies. But who are not excluded—and this may just be an oversight—are executives and shareholders from for-profit corporations such as pharmaceutical companies, biomedical corporations, private health services corporations etc. For example, we don't see what in the bill would stop an executive or shareholder from Carillion Canada Inc, which is one of the companies bidding on the Brampton hospital project—not yet in the health system, but could be in the health system—from serving on the health council, people who have a direct financial interest in the operations of the health system. We actually believe that these people have more of a conflict of interest than some of the people you've actually named in the amendments, and we urge you to look at that.

Also, given the lofty principles in the preamble to the bill, which we support, and given that this committee has received recommendations from dozens of organizations at the public hearings to this, we find it difficult to understand why the health council isn't, at minimum, charged with measuring how the health system is performing with respect to the principles of the Canada Health Act. It seems that that would be central to this piece of legislation. We don't understand that, so we reiterate that recommendation.

In the accountability language of the bill, we note that the amendments to this section seem to primarily reflect discussions that have occurred between the government and provider organizations. As it stands now, this section is notable for its indifference to the recommendations for improved public consultation, procedural safeguards, transparency and any other checks and balances.

We reiterate our recommendations for improved democratic control and diverse representation on hospital boards. As it stands, hospital boards in this province are largely white people from upper-middle-class backgrounds. They don't reflect either patients or staff in the facilities, and they don't represent communities of colour or other marginalized communities.

1650

We recommend improved public access to financial information. We recommend a provision for clear whistle-blowing protection. We don't understand how there can be accountability in the health system unless people who speak out are protected. Many health facilities include gag clauses all through them for workers in the facilities. We recommend a stop to the increasing commercial secrecy pervading the privatized sectors of the health system. Try to get financial information about the P3 project in Brampton, which literally covers almost \$3 billion worth of public money. You can't get it. Democracy and public accountability regarding the delisting of services; accountability for the health minister and providers to meet population need for medically necessary services—that's what the Canada Health Act is about, and that's what protection of medicare would be about.

Public consultation and input from the people of this province, expressly including the users and workers in

the health system regarding proposed changes and restructuring: We're particularly concerned, since in your committee's debate about this section of the bill, several members from the government talked about the desire to basically order health restructuring. Since this province has already been through one very painful round of health restructuring, which has resulted in unnecessary costs and ultimately a diminishment of the scope of services offered under the public health system, we believe there are thousands of people across the province who actually have some meaningful information and input to share before you engage in another round of this. It's a very dangerous experiment to foist on the health system, especially at this point. So we can't urge you strongly enough to set up a process of open consultation, open discussion and public input before engaging in another round of bottom-line-driven health restructuring.

Block fees: Perhaps it isn't clear to the members that the way these fees work is that they're upfront fees charged by physicians for services. If you don't use the services, you don't get the money back. To think there is a fee for a service is pretty questionable. They're a lot more like a premium or a retainer that you give in order to ensure access, essentially. They're very open to abuse, they violate the principles and the spirit of the Canada Health Act—we actually think they violate the Canada Health Act—and they're being more and more widely used across the province.

We applaud the move in this bill to pull the governance of block fees from the College of Physicians and Surgeons into the hands of the government—we believe that's where it belongs—but we reiterate that these block fees should be banned. They're being abused. We've given you five examples of abuse; there are more. But even when they're not being abused, their legitimate usage is a barrier to service. It's a problem, especially in light of the shortage of access to primary care.

Privatization and two-tier access to care: We really went through this in detail in the last submission. I've copied the recommendations from the last submission into this submission, and I just want to say, in short, that if you want to destroy the public health system, if you want to ensure that the costs are unsustainable, that we'll have to shrink the scope of services in order to continue to afford a health system, then privatize it. If you want to ensure there's a universal, publicly accessible health system in this province, then you must stop privatization of the health system and the insidious commingling of two-tier access for so-called medically unnecessary services, which is completely ungovernable in the health system and which will ultimately destroy the public health system. We can't recommend strongly enough that you stop the privatization of the health system and stop the two-tiering that's happening. It's no accident that there is no public, universal health system in the world that's delivered by for-profit corporations, and we urge you to look at that more closely.

The Chair: Thank you very much. We have four minutes remaining. We'll start with the official opposition.

Mr Klees: I note your recommendations under the accountability section with regard to improved democratic control and diverse representation on boards and governing bodies. I agree with you with regard to the need to broaden representation on our local boards, and that all aspects of our community are represented there. Unfortunately it is true in many cases that often an appointment to a board, a hospital board particularly, is simply seen as a feather in someone's cap for something else they've done.

Having said that, I do believe there's a very important role for the local board, as I think you do. But regardless of who's appointed to the board, under this legislation, if it is passed, that local board has no authority any more. So to ask people to come and give their time to a board, any decision of which can be overturned by the minister at the end of the day because the minister chooses to do so—how motivated would people be to participate on that board? I'd be interested in your thoughts on that.

Ms Mehra: I know about the campaign of the Ontario Hospital Association regarding this, and I understand what you're saying about the minister's powers to basically order what he wants in the system—to order restructuring, which is what I think this bill is set up for.

Nonetheless, I think defending the status quo is a mistake. These hospital boards are not representative of the community. In fact, many of them hold closed slate elections, and many of them don't actually involve or accept all community members as members of the corporation. That needs to be changed. We believe that accountability actually happens from them down, not up.

The Chair: Ms Martel.

Ms Martel: Thank you, Natalie, for being here today. I just want to focus on the P3s, because both the Ontario Health Coalition and Brampton have spent some time looking at what documents are available, despite everything that's scratched out on many of them.

What are your concerns with what has been seen in the disclosure of the documents with respect to the Brampton hospital in terms of increasing costs or in terms of what the private corporation will have control over, which isn't just the capital financing any more but actually some of the operations of the hospital?

Ms Mehra: We're trying to do an analysis of the costs, and the costs appear to be much, much greater than any of us imagined in the hospital. That's one concern—the borrowing rate is very high.

We're also concerned because in order to win changes to the deal, it looks like the government provided additional incentives for the corporations, including the ability to build for-profit, ie independent, health facilities on the property. The government ran against for-profit clinics but has actually added into the deal what wasn't there under the previous government, as far as I could find, which is allowing the building of more for-profit health facilities on the land.

So the costs are one problem. The second problem is the deepening privatization, the loss of public control over the facility, the fact that it doesn't comply with the

Public Hospitals Act and the fact that it threatens to kick in the trade agreements and open up the whole system.

The Chair: Next, from the government side, Ms Smith.

Ms Smith: Thanks, Natalie. We're glad you're here today. When you talked about the council, you stated, "We find it difficult to understand why the health council is not mandated, at a minimum, to report on the performance of the health system with respect to the principles of the Canada Health Act."

When I look at the functions of the council, it's to:

"monitor and report ... on,

"access to publicly funded health services,

"health human resources in publicly funded health services,

"consumer and population status, and

"health system outcomes; and

"to support continuous quality improvement."

Other than those things, what do you think is not being reported on by the council under the Canada Health Act?

Ms Mehra: The principles of the act are portability; comprehensiveness—that the system is supposed to provide a comprehensive range of medically necessary services, so how do the range of services offered in Ontario meet population need for medically necessary services; universality—access should be universal, accessibility etc; public funding; and it should cover all medically necessary physician and hospital services.

So delisting ought to be reported on by the council; the non-coverage of medically necessary services; the comprehensiveness of the system, which is shrinking; and the accessibility and universality of the system.

The Chair: We've come to the end of your presentation. I would like to thank you for presenting and wish you a good rest of the afternoon and evening.

Ms Mehra: Thank you.

1700

ONTARIO ASSOCIATION OF OPTOMETRISTS

The Chair: Next, we have the Ontario Association of Optometrists. Make yourself comfortable. You have 15 minutes for your presentation. If you do not use the full time, we will divide it among the three parties.

Dr Shirley Ha: Thank you for the opportunity to present before the committee this evening. As you may recall, this is our second appearance. My name is Dr Shirley Ha. I'm an optometrist, practising in St Catharines, and I am vice-president of the Ontario Association of Optometrists. With me today is Dr. Christopher Nicol, who is also an optometrist with a practice in Bolton. Dr. Nicol also acts as a policy consultant to the association.

The Ontario Association of Optometrists is a voluntary professional organization representing over 1,000 optometrists. We are specifically identified in Bill 8 as the organization representing optometrists for negotiation purposes.

The OAO again welcomes the opportunity to provide the committee with our comments and opinions on Bill 8, including comment on the proposed changes. Generally, we support the bill and the amendments proposed by the minister. We continue to support the establishment of the Ontario Health Quality Council, and we are now satisfied that the proposed changes to part III clearly exclude optometrists. We are pleased that part II, section 14, has been changed to remove the reference to uninsured services.

Notwithstanding these changes, there continue to be some areas that create problems for us. The OAO is particularly concerned with part II of Bill 8, as it relates to payment for an insured service. Optometrists, as well as physicians and dentists, are defined as "practitioners" for the purposes of the Health Insurance Act and the Health Care Accessibility Act.

The OAO regrets that, unlike the Ontario Medical Association, we were not invited to participate in re-drafting the legislation. We are, however, prepared to use this opportunity to identify our concerns to the committee.

I'll now go over the funding history of insured optometric services. Optometrists are now providing the majority of primary eye and vision care in Ontario. More than three million patients a year visit their optometrist for comprehensive eye examinations, including the diagnosis of eye diseases and the management, in co-operation with physicians, of the ocular manifestations of systemic diseases like diabetes and hypertension.

These diagnostic services, for the most part, are considered "insured services" in the Health Insurance Act. Although part II, section 10, of Bill 8 empowers the minister to enter into agreements with the OAO to "provide for methods of negotiating and determining the amounts payable," there is nothing in this section that compels a negotiated agreement or provides for any recourse if negotiations break down. Consequently, a practitioner may never obtain an increase in the amount payable for an insured service despite increases in cost-of-living and practice expenses. Furthermore, section 9 prohibits a practitioner from charging more than the payment established by OHIP.

These two sections in the Health Care Accessibility Act place the OAO at a considerable disadvantage when attempting to negotiate a fair and equitable fee for primary eye and vision care services in Ontario. Consequently, the current fee payable to an optometrist for a comprehensive eye examination has not increased in 15 years. This fact has led to a crisis situation for optometrists and their continued ability to provide quality eye care to the public of Ontario.

During those 15 years without an increase, there have been significant advances in technology and examination standards required of optometrists to diagnose eye diseases and conditions. As independent practitioners, optometrists must assume the costs of these expanded services and new instrumentation. Presently, the fee for the insured service, now unchanged for 15 years, no

longer covers the cost of providing the service, and the profession is concerned about its ability to continue maintaining the standards of care established by the regulatory body, the College of Optometrists.

As the population of Ontario grows and ages, the demand for optometric services will only increase and the required capital investment in new instrumentation will become more and more difficult for optometrists. Optometrists should not be unfairly penalized for ensuring that they provide the highest standards of care to their patients. This sacrifice is not being asked of other health care practitioners.

Currently, optometrists are operating without a signed funding agreement with the provincial government; the most recent one expired March 31, 2000. Fees have not changed since 1989. When one considers inflation, optometric fees in Ontario have not only been steadily declining over the past 15 years, they are now the lowest in Canada.

The OAO is a relatively small organization with limited resources. We have no leverage in the negotiation process, especially when the legislation compels us to accept a fixed fee without recourse to conciliation. Without any provision in the legislation to require either some form of mediation or arbitration, the Ministry of Health and Long-Term Care can continue to force optometrists to accept a completely unrealistic fee.

Under the present Health Care Accessibility Act, optometrists are explicitly prohibited from billing in excess of OHIP fees, or balance-billing, and must accept a fixed payment for any and all services defined as "insured services" by OHIP. This is also the case for physicians and dentists. However, physicians, unlike optometrists, have had periodic increases in amounts payable for insured services from OHIP since 1989. Very few dentists receive payments from OHIP. Non-designated practitioners, such as chiropractors, can balance-bill and are able to offset rising practice costs with private fees. This inability to balance-bill, combined with the ministry's refusal to accept mediation in the negotiation process, has prevented optometrists from maintaining a sufficient income to adequately cover practice costs.

I'll go over some of the proposed solutions the OAO is putting forward.

With the proposed changes in Bill 8, optometrists will no longer be specifically designated in the act itself as practitioners who cannot balance-bill. The proposed changes in sections 7 and 9 of part II will provide an opportunity to permit the designation of optometrists as non-designated practitioners for the purposes of accepting payment. The re-designation to non-designated practitioner by regulation would provide some relief for optometrists from the draconian aspects of the act.

The OAO supports part II, sections 7 and 9, of Bill 8. Furthermore, the OAO asks the committee to recommend that an optometrist be considered a non-designated practitioner for the purposes of the act, at least until such time as outstanding funding issues have been resolved to

the mutual satisfaction of both the Ministry of Health and Long-Term Care and the OAO.

While part II, section 10, authorizes the minister to enter into an agreement with the OAO for methods of negotiation, the type of agreement is not specified. Having established in section 9 that an optometrist must accept payment from the plan as full payment, there is neither a requirement for the ministry to participate in the negotiation process, nor is there a description of the type of agreement for negotiation. This section provides no recourse for the OAO in the event that the ministry either negotiates in bad faith or refuses to negotiate entirely.

The OAO recommends that part II, section 10, of Bill 8 be amended to permit some form of remedy for identified associations, should the fee negotiation process fail to result in an agreement. These protections could take the form of compulsory arbitration or at least mediation. Additionally, the minister should have some responsibility to create an agreement for a fair method of negotiation instead of doing so only at the minister's discretion.

In conclusion, we are pleased with the proposed amendments to the bill and we generally support the purposes of the legislation. Our recommendations to the committee, if accepted, will not only establish a fairer negotiating process for the associations referenced in part II, but will also allow the government to change the basis upon which optometric services are funded. These changes will immediately address the serious inequity of a 15-year funding freeze.

The Chair: Thank you very much for your presentation. We have six minutes remaining. We'll start with the third party.

Ms Martel: Thank you for being here again. I want to look at your proposed solutions, because we've had this discussion before and I just want to put this on the record. I remain very concerned about a proposal that in effect would provide for you to charge a fee. I understand why that proposal is there, but I've expressed to you and I'll put on the record my concern about what that will do for access.

I'm much more interested, if I might, in a proposal that would have some kind of arbitration process, which could be listed in the bill, that would allow your concerns to be addressed. I would be supportive of a recommendation, or a provision in the bill, that would allow that to happen. I think that would clearly point out the need for a fee increase and would at the same time protect as much as possible people's access by not having to resort to an additional fee being paid. I just wanted to put that on the record.

What would happen if recommendation number 2, which I gather would be a form of remedial action, were acceptable? Would that essentially deal with the concerns you have about having a fair way to deal with what has been a lack of a funding increase for 15 years?

1710

Dr Christopher Nicol: That would certainly address that problem. As you know, negotiations have broken

down now, and there's no requirement for the ministry to enter into negotiations again. So in lack of any impetus to create that negotiation or discussion, we have no recourse. We continue to have to accept a fee that's 15 years out of date. So if there was something that would compel negotiations to occur—and even after that, if negotiations broke down—something that would allow recourse to the association to occur—that would help us. Right now we have nothing.

The Chair: Thank you very much. The government side.

Mr Brad Duguid (Scarborough Centre): I want to start off by thanking you for joining us again here today. Thank you for your support for the amendments and your support for the purposes of legislation and for the bill. It's much appreciated that you've taken the time to come here and share your issues with us.

In the minute or less that you have to answer, could you just give us a little bit more in-depth comparison on how—your fees have been frozen for 15 years—that compares to the average fees for other practitioners, doctors and others in different professions?

Dr Nicol: I can't speak for other professions. Certainly, dentistry's fees have increased. Physicians' fees have increased. They have negotiated contracts with OHIP for fee increases continuously in the last 15 years. But because this legislation binds us, we have no way to obtain a fee increase unless the government decides to give it to us. I can't speak for other professions, but obviously other professions have increases in 15 years. Most people have increases in their fees in 15 years.

Mr Duguid: Is it the same across the country, in terms of other provinces? Are you familiar with the field in other areas?

Dr Nicol: Optometric services are funded differently in other provinces. In Ontario, we're the only province that continues to insure routine eye examinations for adults. Other provinces fund differently. Some provinces permit balance-billing: A fee is paid for the services through the provincial health insurance program, and then fees are also obtained from patients privately. But notwithstanding that, the general fee for a basic eye examination is higher in all the other provinces than we obtain from Ontario.

The Chair: Thank you. The official opposition.

Mr Klees: Thank you for your presentation. I'm interested in what your response would be to Ms Martel, who suggests that to allow you the latitude to charge a fee would somehow impact accessibility. I'd be interested in your thoughts on that.

Dr Nicol: All I can say is that it occurs in other provinces. It occurs in Ontario with chiropractors. Patients can access chiropractors—and do all the time—and they're permitted to balance-bill, and other professionals as well.

It's an opportunity for us to be able to maintain a practice, if we can do that. Right now we can't. So it's an option that we propose, and if accepted, it would alleviate the problem that we have.

Mr Klees: I think you're between a rock and a hard place here, because on the one hand, you're subject to a minister who is saying, "I'll negotiate an agreement with you, as long as the agreement is exactly what I expect and want it to be." He can drive you out of business. On the other hand, you're saying, "Well, if you're not going to give us what we need, at least allow us to survive." That is how I understand your submission here, which, for the record, by the way, I support. I think your request is a very reasonable one. I would hope that the minister would hear you on this.

The Chair: There are about another 20 seconds. Any comments? I would like to thank you for your presentation this afternoon. I appreciate it and wish you a good evening. Thank you.

CENTRE FOR ADDICTION AND MENTAL HEALTH

The Chair: Next we have the Centre for Addiction and Mental Health. Welcome, and make yourself comfortable. As with the other presentations, you have 15 minutes, and should time remain, we'll spread it between the parties. Welcome.

Dr Paul Garfinkel: Thank you. I'm Paul Garfinkel, president and CEO of the Centre for Addiction and Mental Health. I'm accompanied by Gail Czukar, vice-president of planning and policy. Thank you for giving us the opportunity to address you today as you consider Bill 8.

The Centre for Addiction and Mental Health, CAMH, had the opportunity to speak to this legislation previously. As you know, we have various mandates. These include a provincial responsibility for care, research, public policy and health promotion and prevention. We've made it a priority to promote positive change in government policy for people with mental illness and addiction, and to ensure that their issues are considered and responded to. It's only appropriate that this depuration take place during Mental Health Week, a week that is designated to promote good mental health and raise awareness about mental illnesses.

The impact of mental illness on our society is staggering. As a government of Ontario press release noted yesterday, one in five of us will experience a mental illness in his or her lifetime and 3% will suffer profound and persistent disablement. Mental illness accounts for 14% of illness-related disability and is the largest cause—about 36%—of short-term disability in the workplace. Despite these facts, mental health and addictions services are largely absent from mainstream health care reform and are not explicitly recognized as an integral part of our health care system. It's on behalf of Ontarians suffering from severe mental illness and addictions, and on behalf of their families, that we appear before you today.

When we addressed this standing committee in March, we made a number of recommendations. Today, in our limited time, we're going to focus on two main points

that bear most directly on Ontario's mental health and addictions community.

Specifically, we recommend that you amend the preamble of Bill 8 to acknowledge the needs of Ontario's citizens who suffer from mental illness or addictions, and to recognize the importance of mental health and addictions services in Ontario's publicly funded health care system. These simple amendments would go a long way to demonstrate that Ontario's elected representatives not only are interested in talking about the need to support the mental health community but are willing to support that talk with actions. After years of neglect, our community requires explicit recognition.

We have also recommended that the government of Ontario proceed with the creation of a health quality council, providing that this council's mandate include studying and reporting on the mental health and addictions sector. Again, we endorse the recommendation put forward by the Canadian Mental Health Association last spring that members of this council include experts in family issues and physical and mental health provision, as well as in patient and consumer issues.

When we appeared before this standing committee in March, we were heartened by the comments of committee members in support of the mental health and addictions community. Needless to say, we were extremely disappointed that the government did not introduce the necessary amendments to the preamble. We were further discouraged when a straightforward amendment to the preamble was voted down by the committee.

As I mentioned to you earlier, this is Mental Health Week, and this week you have another important opportunity to amend this legislation, an opportunity to demonstrate the strength of your convictions and support of the role that mental health and addictions services plays in Ontario's health care system.

The other issue I'd like to briefly comment on is accountability. In terms of the provisions of this legislation to establish an accountability framework, CAMH continues to support the initiative to identify opportunities for greater accountability within the health care sector. We were pleased with the amendments that will result in accountability agreements between hospital boards and the government. We're also pleased that Bill 8 now provides for consultation on regulations, and ask that assurances be given that mental health stakeholders are included in these consultations.

1720

We emphasize the need for the government to work collaboratively with health care providers to develop unique indicators and measures of accountability that meet the needs of the mental health and addictions sector.

Whatever approach the government takes to develop the proposed accountability agreements, it must be flexible to accommodate the special needs of the mental health and addictions sector. Indicators and measurement tools developed for general acute care service delivery have a very limited application to us. Length of stay may mean one thing in the acute care sector; it may mean

something very different when we are so tied to community supports for our patients.

On behalf of the communities we serve, CAMH hopes that, as you consider further amendments to this legislation, you embrace the opportunity before you to make a meaningful statement to demonstrate that you are listening and that you are acting to tackle stigma, and respond to the need to support our mental health and addictions community.

Thank you for the opportunity to speak to this legislation. We welcome any questions you might have.

The Chair: Thank you very much. We have nine minutes remaining. We will start with the government side.

Ms Smith: Thank you very much for coming in to speak to us. I was aware that it was Canadian Mental Health Week because I did a statement on video that I think they're playing on our local cable station at home. "I'm happy to participate and help in making connections"—that's the first part. I can't remember more. It was a couple of weeks ago now. But thank you for being here.

I was interested in your comments about the accountability provisions and some need for change there. I'm a bit unclear from your submissions—perhaps they're in the attached appendix—about what you are looking for with regard to changes on the accountability side, other than, I understand you're looking for flexibility in how to come to accountability agreements because your measurables are different from those in acute care settings. Is that specifically—

Dr Garfinkel: That's the key issue.

Ms Smith: OK. Was there anything else on the accountability side that you—

Dr Garfinkel: I think the idea that now it's a board agreement goes a long way to what the previous concern was. Now we're really saying, be very, very thoughtful in addressing the actual agreement and individualize it for each sector.

Ms Smith: Right.

Dr Garfinkel: Hold us accountable for what is really important in our sector.

Ms Smith: Right, and for measurables that are attainable.

Dr Garfinkel: That's correct.

Ms Smith: OK. I believe my colleague Ms Wynne had a question as well.

Ms Kathleen O. Wynne (Don Valley West): Just briefly, thank you for coming. The way the preamble is written, it's not exclusive of mental health—it doesn't exclude mental health. I think the concern was—and I just wanted to check this out with you—that if we start listing physical and mental, what about emotional? I think the issue is to be broader rather than narrower so as not to exclude. I mean, we are talking about health as it's covered currently. Can you respond to that?

Dr Garfinkel: I think it's a really good comment. We feel our field has been stigmatized for so long that it does need a special—

Ms Wynne: I understand.

Dr Garfinkel: The Canada Health Act specifically excludes our patients. Sometimes when you've been down so long, you do need that extra leg up. But I understand your point.

Ms Wynne: I understand that and I am sympathetic. That's why I'm trying to struggle with it. It's really a societal issue, isn't it: What do we mean by "health"? I think that's why the preamble is written this way.

The Chair: We move to the official opposition.

Mr Klees: Thank you very much for your presentation today. I notice in your appendix you make reference to the importance of pharmacare to mental health and to the health care system. I would just ask you to comment, perhaps a little more specifically, relating to that. Some of us have had a concern that there really isn't anything substantive in this bill that provides direction relating to that. Just how important is that to you?

Dr Garfinkel: The field of treating mental illness and addictions has changed dramatically in the last 15 years. It's highly therapeutic. It's highly successful in helping people through a broad range of psychological, social and pharmacological means. The pharmacology revolution has been extremely important for the group of people with chronic and persistent mental illness who would be cared for in our facility. For many of these people, medication stabilizes them to the point where they are able to live successfully in the community.

Studies that have been done out of Montreal show that even when it's a relatively modest charge to our patients, the compliance falls dramatically and readmission goes up significantly. So we pay for it anyway. We might as well pay for it and have people have a very good quality of life.

Mr Klees: We'll certainly take note of that, and I trust that the minister will hear your message, because it's another of these circumstances where the investment up front is, first of all, the appropriate thing to do for the system and, more importantly, for the people who are being treated, and it saves us considerably in the long term. I appreciate your comments.

The Chair: Ms Martel.

Ms Martel: Thank you for being before us again. I probably will make a comment; I don't really have a question, because the presentation was straightforward.

Because you know there was a vote, I'm assuming you read through the transcript from the clause-by-clause. So you know I didn't put in any amendments because I didn't think the bill could be fixed. Secondly, to her credit, Ms Witmer did. She's not here today, so I want to put on the record on her behalf that she did move an amendment with respect to inclusion of "mental health" in the preamble, and that was voted down by the government majority.

I think it is a matter that will be raised again when we do clause-by-clause and I think there is a way for us to include this in the preamble, and we should do that. So I trust that since you're here again and raising it again, there will be reconsideration by the majority and we will look for a way to have this included in the preamble.

The Chair: Thank you for your presentation this afternoon. Have a good evening.

CREDIT VALLEY HOSPITAL

The Chair: Next we have the Credit Valley Hospital. Welcome to the hearings. When you make your presentation, if you'd state your names for Hansard it would be appreciated. You have 15 minutes. If you don't use the 15 minutes, we'll have questions.

Mr Norm Loberg: Thank you, Chair and members of the committee. Good afternoon, or perhaps good evening, as the case may be.

My name is Norm Loberg, and I'm chair of the board of governors of Credit Valley Hospital. With me today is Barbara Clive, our chief of medical staff, and Wayne Fyffe, our CEO. We're here today in the spirit of co-operation and shared responsibility.

Our board knows our hospital must be part of a health care system that is accountable to the people of Ontario, with access to high-quality health care. Our board is composed of a high-energy group of men and women, chosen for their particular professional skill set to advocate on behalf of our patients and their families. Our board members have gone through a rigorous application and interview process before being elected as members of our board of governors. Our shared commitment is to provide quality, compassionate health care to the growing communities of Halton and Peel through patient advocacy and accountability.

We therefore support the principles in this bill. We are pleased that many of our previous concerns have been addressed in the revisions at second reading, and we thank the minister and you as well. We remain concerned, however, about several aspects of the bill: first, the potential for arbitrary action by the Minister of Health; and second, our inability to advocate for the people in our community to have reasonable access to high-quality care.

In our submission to you on February 24, we asked that section 27 be deleted because it undermines the trust between boards and their CEOs as well as boards and government. We ask again that sections 26 and 27 be reviewed. The suggestions made by the OHA yesterday would eliminate the need for the proposed control mechanisms in sections 26.1 and 27.

Since you've heard from so many boards and CEOs already, we thought we would ask our chief of medical staff to comment on the importance of this bill from her point of view. Although we, as members of the board, feel we represent our community, physicians are closest to the patients, their concerns and their needs.

1730

Dr Barbara Clive: Good afternoon. I am a geriatrician. I care for some of the most vulnerable people in our community.

Accountability in health care must be about patients, meeting their needs and going beyond the black and white rules of legislation in order to better provide care.

That's the human element of running the business of health care. Rules and regulations set parameters, but the human element—the patients—require flexibility. Just as we, the caregivers, have taken a sworn oath to provide the best health care within our abilities, the board is accountable to the people in our community to provide the care they require.

As caregivers, we must advocate for our patients, and that is why I am here today. I do not believe Bill 8, in its current form, will allow us to effectively advocate for our patients.

The Public Hospitals Act clearly defines public interest. The fundamental problem with Bill 8, from my point of view, is the lack of definition of “public interest.” Bill 8 gives the minister the authority to impose his will where “he, she or it”—interesting—considers it in the public interest to do so.

Public interest is all about accessibility. At Credit Valley Hospital, we have a big problem with accessibility. In our hospital, we have 34 stretchers in our busy emergency department. Last week, we had 32 patients waiting to be admitted to an in-patient bed. It is not in the public interest to have to delay emergency assessment and treatment, as well as cancel surgeries, in order to move these patients to an in-patient bed. How can we, as caregivers, and the board members, be held accountable when we aren't given the resources to meet our community's needs?

In 1987, the government announced that it would build an additional in-patient wing at Credit Valley Hospital. At that time, our hospital served a population of about 170,000 people. Today our population has more than doubled, and in 2004, 17 years later, we are still waiting for approval of the new in-patient wing.

Our board has been advocating for “A” wing since it was deferred the first time. Who was accountable? “A” wing is still urgently needed. The board is still advocating because our board believes it is in the public interest to do so, because they are accountable to the men, women and children who need hospitalization.

Let me tell you another story about a real patient. We'll call him Mr Smith. Mr Smith is an elderly gentleman who was born in Ontario, with no close relatives or support. He arrived at the Credit Valley Hospital requiring care without an OHIP number—he had not renewed it for many years. Under the Public Hospitals Act, we cannot deny care to a patient—the human element.

He improved and was ready for discharge. However, he required additional medical care at home or in a long-term-care facility. Without OHIP coverage, he would not be eligible to be admitted to a community care access service program or to a long-term-care facility. In short, our choices were to put him out on the street without adequate medical care or keep him in the hospital and do our best to continue to advocate for his care, which meant getting him his OHIP number.

Was it our job to get him an OHIP card? No. Was it our job to send Mr Smith home to his trailer without support so that a more seriously ill patient could take

over his bed? Yes. Did we do it? No. Instead, our employees spent days—weeks—working through the bureaucracy to get Mr Smith his OHIP card. Was it a good use of our staff's time? The fiscally responsible folks would say no. The patient advocates, the caregivers, the CEO and the board of governors, who are accountable to the people we serve, would say yes.

Under Bill 8, the minister could determine that we were not upholding our accountability agreement—not under the current definition of “public interest.” Our definition of “public interest,” the one in the Public Hospitals Act, tells us we did exactly what we should be doing. The CEO, by condoning this effort to help Mr Smith, was living up to his employment contract or performance agreement with the board of governors. But under Bill 8, he could be seen as contravening his performance agreement with his new master, the Minister of Health. Conversely, in order to uphold his performance agreement with this minister and forgo a penalty or dismissal by the minister, the CEO might have to recommend to the board that we say, “Too bad, Mr Smith. Your time with us is over. It's time to fend for yourself. Out you go.”

Mr Loberg: Thank you, Dr Clive.

In conclusion, we at Credit Valley Hospital believe in accountability. We believe in providing consistent, transparent, fiscally responsible quality health care, and that's Bill 8. But Bill 8 still needs work. It needs a clearer, more patient-focused definition of public interest that aligns with the Public Hospitals Act. It requires accountability agreements that are mutually agreed upon between the board and minister, reflecting equitable access to care and achievable standards of care consistent across the province. Through our accountability agreements with the minister, we will be accountable to government to ensure that our CEO and health care providers uphold the mutually negotiated components of the agreement.

We suggest the committee give careful consideration to the recommendations from the Ontario Hospital Association, in particular the need to clarify that access is part of accountability and the notion that a panel of commissioners be established to quickly arbitrate disputes between the minister and a board. In our view, sections 26 and 27 would not be necessary if the OHA recommendations to amend subsection 21(5) are adopted. We already have a performance agreement with our CEO, so the OHA suggestion that this be made mandatory by amending subsection 21(5) makes perfect sense to us.

Thank you. We'd be happy to answer any questions you have.

The Chair: Thank you. We have six minutes remaining, so two minutes, Mr Barrett.

Mr Toby Barrett (Haldimand-Norfolk-Brant): Thank you to Credit Valley. You've covered much of the waterfront on accountability, and I have heard from a number of hospital boards that feel the original legislation undermined the role of accountability of a hospital board not only to the community but to medicare itself.

You do recommend amendment, and I'm wondering if it goes far enough. I guess I have concerns where a

hospital is directed to sign an agreement that has not been negotiated or agreed to but is unilaterally imposed, effectively eliminating a major part of discussion, negotiation and decision-making. Is the amendment you're proposing going to wrap it up? Is that going to solve this issue? Are you going far enough with your proposed change or amendment?

Mr Loberg: I don't think you can say that in every respect the bill will be perfect, but I think it's a good compromise for a go-forward position.

Mr Barrett: If your proposed amendment—

Mr Loberg: If our proposed amendment is agreed to; yes.

Mr Barrett: Thank you.

The Chair: Ms Martel.

Ms Martel: Thank you for being here today. I don't know what the current Public Hospitals Act says about "public interest" in terms of the definition, and I see you've said we should have a more patient-focused definition that aligns with the current definition.

What happens if the government changes the definition of "public interest" to more closely reflect what's in the Public Hospitals Act now, but still keeps sections 26 and 27?

Mr Loberg: I'll ask Mr Fyffe to comment on that, please.

Mr Wayne Fyffe: Our main point is that the current act talks about access and Bill 8 does not. The second version of Bill 8 is a big improvement over the first. There is quite a long list of things that is included in "public interest," but access is missing. So that's our significant point.

Our point about sections 26 and 27 is the governance issue, in terms of the provisions in there for the minister to invoke penalties and intervene directly through the board, right to the CEO etc. OHA's suggestion of a panel of commissioners etc for the dispute at the front end, when the agreement hasn't been agreed on, and then at the other end where you have an agreement and it isn't being met, is that the same thing is there as a remedy.

Finally, the notion of whether or not a board has a performance agreement: If you just simply amended 21(5), then it would make it mandatory. In our view mandatory is great, because in our practice I've always had a performance agreement anyway, so it wouldn't be a change.

Ms Martel: Just one quick question, just so I'm clear.

Just changing "public interest," if 26 and 27 stayed in place, would not deal with all the questions that Dr Clive raised in terms of what your responsibility is as board and CEO. So it's got to be a combination of both.

Mr Fyffe: That's correct. We believe that access has to be in the public interest and 26 and 27 should go, and the way to make it go is the amendment to 21(5).

The Chair: Mr Delaney.

Mr Bob Delaney (Mississauga West): As the member representing western Mississauga, where Credit Valley Hospital is located, I want to thank you for your continuing and helpful input in the development of the bill and welcome you back to Queen's Park in its continued evolution. I believe Ms Smith has a question for you.

Ms Smith: I appreciate your being here as well. I just want to ask Dr Clive a couple of things.

On your OHIP example, I can assure you that your sitting member will be on the case and getting that gentleman an OHIP card quickly and assisting your staff in doing that, just for the record.

I also want to ask Dr Clive if you are familiar with the dispute resolution provision set out in section 21.1. If the minister were to give notice of non-compliance with an accountability agreement, there's a whole process set out where the notice would have to be given in writing. After receiving the notice, the health service provider has an opportunity to respond in writing. The minister shall consider that response in writing before any compliance directive is issued. I think in the circumstances that you outlined here in your example with Mr Smith, having given those circumstances, I doubt that this would ever be seen as being a violation of accountability agreement. But, that being said, if we're going to use this as the example, I think the dispute resolution provisions that are in the bill now would allow for a great deal of dialogue between the minister and the hospital before a compliance directive was even issued.

Perhaps Dr Clive, or Mr Fyffe?

Mr Fyffe: You're absolutely right. It's a big improvement over the first reading, and there is all that due process in there. But in the end analysis, if we don't come to an agreement—I should say if the board and the minister don't come to an agreement, and let's remember it really won't be the minister himself; it'll be someone else in the ministry until maybe the very end—then the minister will get a briefing and he'll make a decision as to whether or not he uses what we feel are still arbitrary powers in the act to intervene and say, "Thou shalt do that." What we're suggesting in support of the OHA recommendation is that there's another way of doing it that takes that element out of it.

The Chair: Thank you very much. I would like to thank Credit Valley Hospital for your deputation this afternoon.

I would also remind the committee that our next hearing will be on Monday, May 10, at 4 pm. The committee stands adjourned until then.

The committee adjourned at 1743.

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(Hansard)**

Monday 10 May 2004

**Journal
des débats
(Hansard)**

Lundi 10 mai 2004

**Standing committee on
justice and social policy**

Commitment to the Future
of Medicare Act, 2004

**Comité permanent de la
justice et des affaires sociales**

Loi de 2004 sur l'engagement
d'assurer l'avenir
de l'assurance-santé

Chair: Jim Brownell
Clerk: Susan Sourial

Président : Jim Brownell
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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON
JUSTICE AND SOCIAL POLICY

Monday 10 May 2004

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

COMITÉ PERMANENT DE LA JUSTICE
ET DES AFFAIRES SOCIALES

Lundi 10 mai 2004

*The committee met at 1603 in room 151.*COMMITMENT TO THE FUTURE
OF MEDICARE ACT, 2004
LOI DE 2004 SUR L'ENGAGEMENT
D'ASSURER L'AVENIR
DE L'ASSURANCE-SANTÉ

Consideration of Bill 8, An Act to establish the Ontario Health Quality Council, to enact new legislation concerning health service accessibility and repeal the Health Care Accessibility Act, to provide for accountability in the health service sector, and to amend the Health Insurance Act / Projet de loi 8, Loi créant le Conseil ontarien de la qualité des services de santé, édictant une nouvelle loi relative à l'accessibilité aux services de santé et abrogeant la Loi sur l'accessibilité aux services de santé, prévoyant l'imputabilité du secteur des services de santé et modifiant la Loi sur l'assurance-santé.

CATHOLIC HEALTH CORP OF ONTARIO

The Chair (Mr Jim Brownell): I would like to call the meeting to order and welcome the committee and those making deputations this afternoon.

We have for the first deputation the Catholic Health Corp of Ontario. I'd like to welcome you to the table. You will have 15 minutes for your presentation. Should you not use the time, we will split the remainder of the time between the three parties for questions and answers. Welcome. Please state your names when you present, so we can get them recorded for Hansard.

Mr Mark O'Regan: Thank you very much. My name is Mark O'Regan. I'm the vice-chair of the Catholic Health Corp of Ontario. To my left is fellow director Mimi Marrocco. To my right is Don McDermott, the president and CEO of the Catholic Health Corp of Ontario. Thank you for this opportunity to meet with you today—especially for going first—to consider further the amendments to Bill 8.

We represent the sponsoring organization for 13 Catholic health institutions in the province. We represent a total of 929 acute beds, 2,600 long-term-care rehab and psychiatric beds, governed by over 180 directors in eight Ontario communities. Mimi and I are going to share the presentation today. It's less than 10 minutes. Don

McDermott will get the tough part, and he'll handle all your questions.

The Catholic Health Corp of Ontario was incorporated under the Canada Corporations Act in 1998 by the Sisters of St Joseph of Toronto, the Sisters of St Joseph of Sault Ste Marie, the Grey Sisters of the Immaculate Conception of Pembroke and the Catholic Health Association of Ontario. We have recently been joined by the Sisters of Charity of Ottawa.

As an organization to carry on its work in the name of the Catholic church, it is subject to canon law. Canon law requires it to have a sponsor to ensure its work is done within the values of the church. CHCO is such a sponsor for our 13-member institutions.

Previously, the congregations of sisters who founded the institutions acted as sponsors. Now the sisters are moving to other works and the Catholic Health Corp of Ontario has taken up the responsibility of sponsorship. In every case, the sisters retain ownership of the institutional property.

As sponsors, we delegate the operational governance of these institutions to voluntary institutional boards of directors. These directors, having the expertise required to govern a health care institution, are drawn from the communities where the institutions are located and represent the diverse nature of the communities, including ethnicity and religion. All the directors of our institutions support the mission and values of the faith-based approach to the provision of health care, within canon law and the laws and standards set out by the Ontario and Canadian governments. Faith-based institutions such as ours provide our mission-based services through the actions of these voluntary boards and the CEOs who work for and report directly to the governing boards.

We were privileged to meet with this committee on February 23, when it was considering amendments to the bill at first reading. As always, we recognize and agree with the intent of Bill 8: to ensure accountability within the health care system in Ontario and to preserve and ensure quality health care for the patients and clients requiring these services. We are fully in accord with the tenets of the Canada Health Act, including public administration that is accountable to the public. We are pleased that the standing committee recommended significant revisions to the bill at that time.

It is a step forward that early amendments have deleted any requirements to have the CEO contract

directly with the ministry, ensuring that the CEO remains accountable only to the governing board. We are also heartened by the provision of a due process for disagreements, and we welcome the inclusion of the public interest clause and other changes that were requested. Thank you for listening to our collective concerns.

Two major concerns remain with us. First, we fear that the wording of the legislation or its regulations will be used in future to minimize the role of the governing body or to compromise the values of the faith-based mission. For example, an institutional board could be obliged to sign an agreement that requires the provision of services contrary to our faith, or to partner directly with an organization that provides services that are contrary to our values. Therefore we support the proposal by the Catholic Health Association of Ontario and other faith-based institutions that you will hear tomorrow, May 11, for an amendment to the bill to state unequivocally that nothing within the legislation or within its regulations is intended to compromise the faith-based missions, ethics and values of the institutions or their owner-sponsors.

At this point, I would ask Mimi to conclude the formal part of our presentation.

Dr Mimi Marrocco: Thanks, Mark. My name is Mimi Marrocco and I'm a director of the Catholic Health Corp of Ontario.

We believe that this amendment would ensure that the legislation retains its original intent, namely that institutions are accountable to the public for their services and for the delivery of these services within their values and ethics. Such an amendment would be a simple confirmation of the assurances previously made by the provincial governments to us and to the owners and sponsors of religious institutions.

In a letter written to the Catholic Health Association of Ontario on August 27, 2003, the Honourable Dalton McGuinty, Premier of Ontario, wrote that "the Ontario Liberals are committed to preserving the Catholic health ministry in our province. We appreciate that governance issues are of the utmost importance if Catholic hospitals, long-term facilities and home care providers are to preserve their ministry."

Currently, as you're no doubt aware, other provincial agreements with their faith-based health care providers recognize and affirm their long-standing and valuable role within the system and their need to maintain their religious mission. We cite the following as examples:

Saskatchewan's district health board and affiliates agreement states in section E:

"It is recognized that the affiliated agency, a Christian institution in the Catholic tradition,

"1. is an integral part of the health system and has an evolving role to play in the health reform initiatives in the district and Saskatchewan;

"2. shall remain a privately owned corporation governed by its own board of directors or in some publicly recognized manner;

"3. has a stewardship role in maintaining its Catholic mission, values, ethics;

"(4) shall carry out its mission, programs and services according to the principles and guidelines of the Health Care Ethics Guide, as approved from time to time by the Canadian Conference of Catholic Bishops."

1610

British Columbia's master agreement of March 1995 states in section 1:

"The minister acknowledges that ownership and title to the facilities set out in schedule A and those additional facilities as may be added from time to time by the owners in furtherance of their religious mission belongs to the respective owners set opposite their names and they shall continue to enjoy the powers and privileges of ownership including, without limiting the generality thereof, the right to determine the context of their respective values and traditions, the mission and values of the owner so as to preserve the spiritual nature of the facility, to establish such medical staff bylaws as they deem necessary to safeguard the mission and values aforesaid and the right to govern the facility, appoint a chief executive officer and approve and implement a staffing plan."

Alberta's agreement with the Catholic Health Association of Alberta, May 1996, states in article 3:

"The co-operation agreements shall recognize that the ownership and operation of voluntary health facilities shall be retained by the owner/operators (or such other entities as the religious group or society they represent shall appoint in their stead from time to time) who shall continue to have the ability to:

"(a) determine the mission, values, ethical principles and guidelines of the voluntary health facility;

"(b) direct, regulate and appoint a governing board for the voluntary health facility," referred to as the facility board;

"(c) participate with the facility board in the selection and employment of a chief executive officer for the voluntary health facility."

The letter of understanding between the province of New Brunswick and the New Brunswick Catholic Health Association of April 1993 states in section 1:

"The mission statements that have been associated, or will be established, with respect to the delivery of services at the religious hospitals will be adhered to and this will be reflected in the regional hospital corporations' bylaws. Only services consistent with the above will be provided in the religious hospitals."

As noted by Mark earlier, in February we recommended that if a dispute is centred on the application of the religious mission, ethics or values of a Catholic institution, the bishop of the diocese within which the institution is located should determine the ability of the institution to comply within church law.

We'd like to conclude by expressing our major concern, and then leave you with two recommendations. Our concern is that the contracts, or the accountability agreements, between institutional boards and government could potentially interfere with the voluntary governance process, especially with faith-based institutions, where

this governance process is the way that we carry out our religious mission.

So we'd like to recommend two things: first, that a clause be inserted into the legislation to ensure that current and future interpretation of the legislation will not interfere with the mission, ethics or values of the faith-based institution or its services; secondly, that a third-party resolution process, mutually agreeable to both parties, be developed for any disputes which arise during the negotiation process and after, when interpreting the agreement. We recommend consulting the local bishop where Catholic ethics and values are in question.

We thank you again for hearing us. We'd be pleased to answer any questions that you may have.

The Chair: Thank you very much. We have about four minutes remaining, so we'll have to have quick questions and answers. We'll start with the official opposition.

Mrs Elizabeth Witmer (Kitchener-Waterloo): Thank you very much for your presentation. The first one is of course your concern about the interference with faith-based institutions. Do you have a clause that you would recommend to be inserted? Do we have a copy of that?

Mr Don McDermott: Don McDermott speaking. The Catholic Health Association of Ontario, when they present tomorrow, will have specific wording that we have reviewed and agree to. So they have identified a clause that they're recommending.

Mrs Witmer: Which would address that concern that you have.

Mr McDermott: That addresses our concerns. That's right.

Mrs Witmer: OK. Thank you very much.

Mr McDermott: It parallels the other provinces' wording in their agreements.

Mrs Witmer: Good. I'll look forward to seeing that.

Ms Shelley Martel (Nickel Belt): Thank you for being here today. The three agreements and the fourth letter of understanding that you referenced between various provinces: Were those agreements around funding, or were they broader than that?

Mr McDermott: No. It's an agreement that includes broad wording around funding. Yearly, there are budgets that are worked out with these provinces and their regional authorities. But it is a master agreement, essentially, that identifies services and funding around those services, and then specifics of funding come on a yearly basis.

Ms Martel: They're worked out annually after that?

Mr McDermott: To my understanding.

Ms Monique M. Smith (Nipissing): Thank you very much for coming today; we really appreciate your input. In the agreements the long-term-care facilities sign with the government right now, is there any language similar to what you reflected from the other provinces?

Mr McDermott: Not to my understanding, and we certainly would appreciate it if there were the opportunity to have some mission protection in those agreements.

The Chair: Thank you very much for your presentation. We wish you a good afternoon.

REGISTERED PRACTICAL NURSES ASSOCIATION OF ONTARIO

The Chair: Next we have the Registered Practical Nurses Association of Ontario. Step up to the table and make yourself comfortable. There is water and juice at the side, if you like.

You have 15 minutes for your presentation, just as with the last deputation. If there's time remaining, we'll have questions starting with the third party. Welcome.

Ms Joanne Young Evans: Thank you very much. My name is Joanne Young Evans, and I'm the executive director of the Registered Practical Nurses Association of Ontario, generally known as RPNAO. With me today is Beth McCracken. As the deputy executive director, Beth is the most recent member of our team and is also a registered practical nurse.

The RPNAO is a voluntary professional association that has represented registered practical nurses, or RPNs, since 1958. Our association represents nearly 5,000, or 14%, of the 32,000 RPNs registered to practise in Ontario by the College of Nurses of Ontario. Our members work in a variety of settings, including acute care facilities, long-term-care facilities, community health, occupational health and many other venues within our health care system.

It is a great pleasure to appear before you today on a bill that is of great importance to the future of the health care delivery system in our province. As you may recall, we provided our comments and recommendations to you during the first round of public hearings, prior to second reading. We are pleased to be back to provide further comments on Bill 8.

Bill 8, the Commitment to the Future of Medicare Act, 2003, was introduced early in the mandate of the new government. It is viewed by many as a signature piece of health care legislation that was to define the new government and to distance it from the previous one. This legislation was portrayed as a clear commitment to make universal, public medicare the law in Ontario. It was said that this bill would outlaw two-tier health care in Ontario. This legislation, we were told, would enshrine into law that every citizen in Ontario would have access to timely, quality and affordable health care.

After a thorough public hearing process prior to second reading, several amendments were made to the bill. We were told that these amendments would make the bill clearer and transparent, and truer to its purpose: to preserve and strengthen medicare in Ontario. We were also told that the bill would provide enduring protection for publicly funded, universal health care in this province, now and for generations to come.

As the association representing RPNs in this province, we have a great interest in the future of health care in Ontario. RPNAO's members support the public health system. We want our patients to be able to rely on it and

to be able to access the necessary services they need in a timely manner. However, in order to do this efficiently and effectively, RPNs and other health care professionals require human, physical and financial resources.

With respect to nursing in particular, this government has already taken some steps to address some of the problems within the system. We welcomed the recent announcement of funding to hire 400 more nurses in small and rural hospitals. I would caution the government, however, that RPNAO trusts this funding will be used to hire both categories of nurses, RPNs and RNs alike. As well, we also hope this funding will not be used to hire one category of nurse at the expense of another.

1620

RPNs play an important role on the health care team. Yet there are hospitals that continue to prevent RPNs from practising to their full scope of practice. In fact, some hospitals have laid off RPNs or displaced them into non-nursing roles because of the myth that RPNs are unable to handle complex and acute cases. This, of course, is occurring at a time when a supposed nursing shortage is occurring in Ontario.

The preamble to Bill 8 states that the bill endorses the Canada Health Act and primary health care, that two-tier health care would be prohibited and that our health care system would be a consumer-centred system that ensures access and is based on need and not on an individual's ability to pay. The preamble also states that the bill will promote accountability in our health care system "that reflects the public interest" and that promotes efficient delivery of high-quality health care services.

You'll have to excuse us. We've been up since 7 this morning at a nursing career fair, so it's been a long day, as I'm sure it has been for you.

RPNAO supports all these objectives. We are concerned, however, that the content of Bill 8 does not contain the necessary elements necessary to fulfill these objectives.

Bill 8 is supposed to be about improving accessibility in the health care system. It was to reduce the wait times for such things as MRIs and CT scans, and it was also to prohibit queue-jumping for essential health care services. Unfortunately, Bill 8 fails to do so. In fact, it makes no mention of prohibiting private hospitals or MRI and CT scan clinics. Bill 8 also does not indicate how wait times will be reduced.

As we indicated to you in our previous submission, we support the establishment of the Ontario Health Quality Council. We are pleased that further changes have been made to this section of the bill that will ensure a more effective and productive council. The council will be an important step in supporting the Health Council of Canada. RPNAO suggests to you, however, that this council be an independent council reporting directly to the Legislative Assembly rather than the Minister of Health and Long-Term Care or to any other member of the executive council.

Ms Beth McCracken: Part II of the bill deals with accessibility. In principle, we support this part. We are

pleased that amendments have been made with respect to the protection of personal health information, specifically as outlined in section 13. Our concern prior to the amendments was that this section of the bill would create another stream of access to, and disclosure of, health information. We were concerned that Bill 8 would prevail over Bill 31, the Personal Health Information Protection Act, 2004. We are pleased that Bill 8 has now been amended to provide a single regime for the protection of health information falling under the jurisdiction of Bill 31, on the condition that Bill 31 is proclaimed.

Part III of the bill deals with accountability. Despite numerous amendments that have been made to this part, it still causes great division between the health care sector and the government. What is set out in part III continues to be a heavy-handed and one-sided approach to enforcing health resource providers.

We suggested to you in our previous submission that without substantial revisions to Part II, one outcome of the bill would be a hostile relationship between the government and health service providers. We believe the changes that have been made do not entirely quell those fears.

Let me say that there have been changes to this part of the bill that we applaud the government for making. The bill has been amended to explicitly exclude individual practitioners and trade unions from accountability agreements and compliance directives. Amendments have also been made to exclude collective agreements from being overridden by compliance orders. Again, this is a concern we brought to you in our previous submission, and we are pleased it has been addressed.

RPNAO is still concerned, however, about the extraordinary amount of power that is granted to the minister. The minister of the day will still have the authority to direct health service providers to enter into an accountability agreement or issue compliance directives. The difference now is that the health service provider and the government can negotiate such an agreement or directive for 60 and 30 days, respectively, but if negotiations fail to reach an agreement, the minister may move unilaterally. Aside from this delayed unilateralism, if I can call it that, what is the incentive for the ministry to negotiate in good faith if it knows it can ultimately have its way?

The minister also has the authority to implement onerous fines on the board of our health care facilities, many of whom are volunteers. RPNAO recommends that the power of the minister be subdued significantly by appointing a supervisor for those cases where accountability agreements or directives can be negotiated within a designated timeline. This supervisor would ensure that both government and the facility negotiate in good faith. The supervisor will review the situation and the supervisor will make recommendations on how best to achieve the agreement.

With this approach, an agreeable solution will be sought and an accountability agreement will be developed through co-operation rather than coercion. It will also diminish any hostility created in the health care

system as a result of implementation of this legislation as it is currently written, and increase the facility's commitment to the agreement.

RPNAO also recommends that for part of the accountability agreements there should be a provision that an employment environment be conducive to all nurses working to their full scope of practice, utilizing tax dollars much more effectively and efficiently than at present. We would like to see included in the agreements proof that all publicly funded facilities hire both categories of nurses. This will ensure that new funding, for example, given to hospitals to hire more nurses will be used for just that purpose and not for salary increases for hospital executives or senior staff, as has occurred with the funding that has just been announced a short while ago.

As well, other hospitals are hiring only one category of nurse. This is slowly phasing out another category. In fact, we were just informed that the University Health Network in Toronto is moving toward an all-RN staffing arrangement. Any new funding that is received for hiring nurses will only be used to hire registered nurses. Furthermore, as registered practical nurses leave or retire, an RN will be hired to replace them.

Given that RNs receive a higher salary than RPNs, the amount of money that will be spent for hiring more nurses will be used to pay nurses more, rather than paying for more nursing. This, despite RPNs being just as capable and equipped to fulfill the role. I stress to you that RPNs are more than qualified to work in acute care, as well as in other areas within hospitals. They are a necessary and an integral part of the overall health team, and we need to ensure that they remain included. In fact, we can give you dozens of examples of award-winning collaborative nursing teams in health care facilities across this province.

In closing, I would like to thank you for the opportunity to appear before you again. We appreciate the open dialogue that Bill 8 has been receiving, and RPNAO truly hopes that, based on the suggestions and recommendations that you're receiving from various stakeholders, amendments will be made to the bill to truly protect medicare in Ontario.

We would be pleased to address any questions.

The Chair: Thank you very much. We have four minutes remaining. Ms Martel, a very quick question and answer.

Ms Martel: The question has to do with your solution around dealing with the agreements. There are literally thousands of agreements that will have to be dealt with. I don't think they're going to be dealt with in 30 or 60 days. You've got a suggestion for a supervisor at the front end, which we appreciate. There has also been some suggestion that we should have, at the back end of the process, an independent dispute mechanism in some way, shape or form, to deal with disputes that are ongoing. I'm assuming you agree with that proposal as well?

Ms Young Evans: Yes.

Ms Martel: OK. One other question. You talked about the contradiction—I mean, that's what it is. You

didn't say it in your words. I'll say it, and you can either tell me if I'm right or wrong, but there is a contradiction between the preamble, which talks in glowing terms about medicare, and a bill where the contents do not shut down the private hospitals or the private MRIs. Do you see that as a contradiction? Do you remain concerned?

Ms Young Evans: We remain concerned.

Ms Kathleen O. Wynne (Don Valley West): Just a quick question about the supervisor mechanism. By the way, thank you for coming today. On page 4, you talk about the supervisor who would make recommendations on how best to achieve an agreement in the event that an agreement couldn't be reached. What is the accountability of that supervisor? Have you talked or thought about that? How would that work?

Ms Young Evans: We haven't looked at that in detail, but we think that a supervisor would be much more capable of dealing with this situation than handing it over to the minister. In the end, it wouldn't be the minister who deals with it anyway, so if you have someone who can walk into a hospital situation, who is familiar with how hospitals work, how the contracts work, they would be much more capable and knowledgeable in skill and judgment, to use nursing terms, to actually deal with the situation.

1630

Ms Wynne: We have to talk more about the accountability. Mr Leal had a question.

The Chair: It has to be quick.

Mr Jeff Leal (Peterborough): It is very quick. Thank for sharing. Thank you very much for arriving.

You talk about the accountability agreement and 60 days to reach a conclusion. It seems to me from when I was in municipal politics, when we had collective agreements pending with our unions, we used to start a year in advance—

The Chair: Fifteen seconds.

Mr Leal: —to get an agreement. Wouldn't that be commonplace, knowing that this legislation is coming in, to say, "A year in advance we're going to start to get these accountability agreements discussed and signed," rather than just waiting for the last 60 days?

Ms Young Evans: But that doesn't even happen with our contracts today.

The Chair: Thank you.

Ms Young Evans: And they would be accountable to the minister, so—

Mr Leal: I was just speaking from my experience.

The Chair: Thank you. Mr Klees.

Mr Frank Klees (Oak Ridges): Thank you for your presentation. Actually, Mr Leal makes the point that I want to zero in on. You've, rightfully so, pointed out the fact that in spite of all of the amendments, there is still one major problem—and it's not just you; it's really all the stakeholders who continue to point to this extraordinary power and authority that's still left with the minister. Whether you start negotiating a year ahead of time or within the 30- or 60-day period, the fact of the matter is, in this legislation, regardless of what happens,

if the minister feels that it's not the deal he or she wants, it's over, and he or she will make that deal.

I'd like to know what the implications are to your profession under this kind of authority given the Minister of Health.

Ms Young Evans: As we indicated to Ms Martel the last time we spoke, because she asked a very similar question, they can go in and change those particular contracts. They can change hours, they can change pay, they can change a number of things. That is extremely detrimental to us, particularly with RPNs being represented by about 20 different unions, unlike the registered nurses, who are basically represented by one union in the hospital situation.

The Chair: Thank you for your presentation. I wish you a good afternoon.

ONTARIO COUNCIL OF TEACHING HOSPITALS

The Chair: Next we have the Ontario Council of Teaching Hospitals. Please make yourself comfortable. Should you need water or juice or anything, we do have them. Welcome.

Mr Murray Martin: Thank you very much. First, I apologize for the copies of our presentation. It will be handed out in a few moments as it was late arriving.

My name is Murray Martin. I'm the chair of the board of the Ontario Council of Teaching Hospitals and I'm the president and CEO of Hamilton Health Sciences Centre. I'm joined by Barbara Sullivan, who is a member of our board of directors at Hamilton Health Sciences Centre.

We believe this is an opportunity to reiterate our commitment to enhance accountability in the health care sector, to underline our joint role with government in developing appropriate funding formulae for Ontario's hospitals, to mutually determine expected outcomes of the services we provide, and to promote a rational piece of legislation that will become the accountability mechanism for many years to come.

We want to recognize and commend the minister and the standing committee for the significant amendments that have been made to the original bill. A number of important issues have been clarified and some of our initial concerns have been addressed. We want to emphasize, however, that the proposed accountability agreements must be negotiated using the best information available to provide care that meets the needs in each community that a hospital serves and that there is a recognition of the transition costs—monetary, professional health resources and technology—and timelines required to integrate services where that is agreed to be the appropriate direction in meeting regional health care needs.

Given the substantial revisions that have been made to the bill, we believe these hearings provide not only the opportunity to propose further amendments, but also to confirm expectations with respect to the execution and

implementation of the accountability agreements in the real world.

Today we want to propose specific suggestions to further improve the legislation. OCOTH believes that additional amendments to Bill 8 are needed in the following specific areas:

Part I, Ontario Health Quality Council: We recommend that the role of the Ontario health council be expanded to allow it to make recommendations based on the information it has collected and reviewed.

Part II, section 9, under physician payments: We recommend that section 9 be amended to allow for a narrow range of payments to physicians. As originally drafted, section 9 prohibited any payments to physicians whatsoever.

In our first presentation, OCOTH proposed that this section be amended to allow a narrow range of necessary payments to physicians, such as hospitalists, lab physicians and those working under an alternative payment plan. At the standing committee, the government proposed amendments which effectively permit payments by hospitals to any and all physicians. Indeed, the ministry confirmed that the intent of this change will allow for top-up payments. As a consequence of these amendments, the bill will allow physicians to have, in effect, two mechanisms for payments: one charged to the hospital, the second to the provincial insurance plan. OCOTH members are strongly opposed to this amendment and propose the suggestion that we have.

Just by way of discussions with hospitals already, I've had other CEOs tell me that their physicians have already said to them, "Now this has been changed in Bill 8, we want to begin negotiations with you about our top-up." The reality is, with a shortage situation, this will simply create a bidding war among hospitals, upping the price, and add no more medical manpower to the province. This is a very serious issue.

Accountability agreements: For many years, Ontario hospitals and the Ministry of Health and Long-Term Care have worked on a made-in-Ontario, service-based funding formula. This formula would respond to a number of key policy objectives, including equitable access to care, efficient hospital operations, efficacy and high quality of care and stability and predictability in hospital operations.

At its base is accountability, since it's a truly rate-times-volume approach, where individual hospitals are reimbursed for the services they provide under terms and conditions specified in a mutually negotiated agreement between the government and the hospital. This is a new approach in Ontario and the proposed formulae have yet to be fully tested.

The question of possible service gaps in some communities is a large one and one of concern. The availability of appropriate data to determine the rate and the planned volumes is also a significant challenge. Issues that are of particular concern to teaching hospitals include patient acuity and the cost of teaching and research, which will require special attention.

Throughout the work of the JPPC, it has been clear that the accountability agreements that result from a move to service-based funding should be mutually agreed upon and should be phased in gradually. This bill makes the assumption that suitable service rates have been categorically established, and that volume projections are not only actuarially based but speak accurately to disease and condition incidence in a wide variety of communities across the province—and there is wide variation. It also presumes that service integration will always reduce costs and ensure a higher standard of patient care. The truth is that there is far from any evidence of this assumption.

Work is proceeding, and reference hospitals have been involved in the examination of many details that will lead to competent templates. In this context, therefore, we propose that additional amendments be made to sections 21, 26.1 and 27.

One of the further concerns we have is the ministry infrastructure to, in actual fact, effect these agreements. We need to see more evidence that that infrastructure is being put in place, because this is going to be a complicated exercise and it's going to require change.

We're pleased that the ministry recognizes through amendments the importance of negotiated accountability agreements. However, section 21 still permits these agreements to be imposed by the minister after a period of 60 days without appeal or necessarily taking into account a hospital's realistic view of whether the agreements can be successfully carried out or achieved in what time frames.

The provision that allows the minister to unilaterally alter/impose agreements should be deleted. As an alternative, OCOTH proposes that in the event that an accountability agreement cannot be reached at the conclusion of 60 days, a third party chosen from an agreed-upon roster of highly skilled individuals with strong knowledge of the hospital/health care sector would review the matters under consideration or in dispute and make recommendations within 30 days to the minister and the hospital board for resolution of the issues outstanding so that a satisfactory agreement can be entered into. The results of the third-party review should be made public. We consider that this will be an unusual situation, but sober thought may lead to a workable mutual agreement that might otherwise be unattainable.

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Ms Barbara Sullivan: We also recommend that paragraphs 1/2 of subsection 26.1(6), subsections (11), (12), (13) and (14) of subsection 26.1 and section 27 be deleted. In our view, it's important that a board be accountable for the CEO's execution of the accountability agreement, and this is explicitly addressed in section 21(5) of the bill, as amended, which we recommend could be made even stronger by changing the words "may provide" to "shall provide". We believe that this combination of changes will ensure that the board's responsibility to the minister under the accountability agreement is clearly spelled out in its CEO contracts and

eliminates the untidy and controversial intervention of the minister in employment contracts between boards and CEOs. We further recommend that performance agreement guidelines—and I say guidelines—be jointly developed by the ministry, OCOTH and the OHA with clear reference to the board's accountability agreement with the minister, along with penalties and incentives specified.

These proposed amendments are consistent with the minister's recent public statements with respect to his desire to hold boards accountable and would avoid the need for the draconian control mechanisms in sections 26 and 27 of the bill. We think they're simple and workable.

Our final message has to do with implementation of the bill when passed. There's a critical need to ensure that there continues to be strong collaboration between health care providers and the government during the implementation of this legislation. Murray has already spoken of that. At present, there is a lack of clarity concerning how the agreements will be implemented, including the timelines for implementation. We need to work together to make the development of these agreements manageable and useful from a systems management and planning perspective.

Accordingly, our recommendations are as follows:

That the Minister of Health and Long-Term Care ensure that the development of accountability agreements will be based on principles of transparency and flexibility;

That the minister consult with health resource providers impacted by Bill 8 to develop a clear plan on how execution of the accountability agreements will unfold. This will ensure that processes and timelines are clear, and that there is equal treatment across boards;

That the minister re-confirm the commitment to involve health resource providers in the development of the regulations supporting this bill. We know that the minister committed to that in his statement to the committee. We want to underline the importance of that commitment.

We also believe that the minister should verify the linkage between the work that has been undertaken to date by the joint policy and planning committee, JPPC, to develop an accountability framework, and the proposed accountability agreements which are contained in this bill. More information is required by all participants on proposals for the agreement templates and how they will be fully developed.

The further amendments to the bill which we propose, along with a clarification of implementation measures, will, we're convinced, ensure a viable hospital funding mechanism, publicly measurable accountability vehicles and co-operative, coordinated provision of health services in this province. We share your commitment to these goals, and we thank you for having us back today.

The Chair: Thank you for your presentation. We have four minutes remaining. We'll start with the government side.

Ms Smith: Thank you, Mrs Sullivan and Mr Martin. I appreciate your being here today. We really appreciate

your input. I want to ask a little bit about the JPPC accountability framework. How do you see that linking up with the accountability agreements in the future? My understanding was that was going to form the basis of the accountability agreements. Do you see that working?

Mr Murray Martin: That is our understanding, but, to be frank, we're not sure. We want to make sure that the significant effort that's been put in through JPPC, which involves hundreds of people from the health care system, in actual fact is what results in the agreement. With the legislation and still-to-be-drafted regulations, it could go in a different direction, and we are concerned about that.

Ms Smith: Are you involved in the JPPC discussions?

Mr Murray Martin: Yes, I'm on several of the committees myself. At JPPC, there is an overriding understanding that this is the process, but there is always the uncertainty as to whether that will continue to be the case.

Ms Smith: But the understanding right now is that this will form the framework for the accountability agreements.

Mr Murray Martin: Yes.

Ms Sullivan: That's the understanding of the JPPC, but that may not be broadly understood through the hospital and other sectors.

Mrs Witmer: Actually, I had some questions around the JPPC as well. A lot of work has been undertaken, and I don't think anybody quite understands for certain how it's going to be used as we develop the agreements for individual hospitals.

You've talked about the fact that the implementation of the agreements is going to be critical to the success of the implementation of Bill 8. What would you recommend that the ministry do in particular to ensure a smooth implementation?

Mr Murray Martin: I think what is most important is that it actually be phased in, that there be real pilots and that there not be an attempt to fast-track it so that it's actually ahead of where the data is. This is going to be very complicated and there are some aspects of it that may not work as they were intended. There's new ground to be broken in terms of understanding the impact, particularly of the volumes part of the formula. What we would hate to see is that we rush into it and hold organizations accountable to something that is unrealistic and unreasonable.

Ms Martel: Thank you for being here. I have to say that even the timing of putting those in place is completely unrealistic. Setting aside the power that the minister has to impose, which I disagree with, and we have from the start, are the questions of (a) the ministry's human resources to manage this and (b) just the timelines. We're talking about hundreds of hospitals, hundreds of long-term-care facilities, thousands, I would think, independent health facilities and 56 or 57 community health centres. I believe you expressed a concern about resources, generally, at the ministry. How is this ever going to unfold in the timeline that's actually listed in the bill?

Mr Murray Martin: There certainly will need to be a major gearing up within the ministry. There's going to be the need, frankly, to recruit some additional infrastructure to support this. There is skepticism out there. The ministry in past decades has not had a good track record of overseeing contracts. They've been allowed to lapse, with long timelines between renegotiations. You have an industry that's very skeptical about the ministry's ability to take this on without significant work being done.

Ms Martel: Or significant human resources, would be the other issue.

Ms Sullivan: I think it's fair to say too that, for the hospital sector, the work of the JPPC in developing the accountability frameworks enables the hospital sector to be significantly ahead of some of the other sectors that are going to have to be involved in developed accountability agreements as well.

The Chair: We have about 20 seconds.

Ms Sullivan: OK. Just to go back to those JPPC frameworks, they include policy consideration, performance requirements, a performance indication ladder and a process for remediation. None of those things, frankly, have been spelled out in full so that they can be totally implemented today.

The Chair: Thank you very much. We appreciate your attendance here today and we wish you a good evening.

ROUGE VALLEY HEALTH SYSTEM

The Chair: Next we have the Rouge Valley Health System. Welcome. As in the past, you have 15 minutes, and any time remaining is split between the parties. Make yourself comfortable. You have the floor.

Ms Kathryn Ramsay: Thank you very much. My name is Kathryn Ramsay and I'm chair of the Rouge Valley Health System board of directors. With me here this afternoon is Mr Hume Martin, CEO and president.

The Rouge Valley Health System was formed in 1998 following the Health Services Restructuring Commission directive to merge Ajax Pickering General Hospital in Durham and Centenary Health Centre in Scarborough. The vision of Rouge Valley is to be a leader in the delivery of family-centred care for the 500,000 residents we serve.

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Since 1998, Rouge Valley has made a large number of improvements at both sites, which are detailed in your brief and I won't go into them specifically.

The ministry supported Rouge Valley in the achievement of many of these improvements, but the financial investment made by Rouge Valley to implement Health Services Restructuring Commission recommendations ultimately resulted in a deficit of over \$16 million and a working capital shortfall that exceeded \$31 million.

Over the past six years, the two previously separate hospital foundations merged and launched a \$34-million capital campaign to support necessary expansion and redevelopment at both Rouge Valley sites. Rouge Valley

put in place cross-site management and appointed common medical staff leadership for eight of our 10 medical services.

We also played a remarkable, if unheralded, role during SARS. At the epicentre of the outbreak, we cared for 49 SARS inpatients and, through a combination of rigorous infection control practices, dedicated frontline staff and good fortune, avoided transmission of the disease to other patients and staff.

In 2002, the board made a proposal to the Ministry of Health and Long-Term Care to negotiate a financial and service agreement to maintain and enhance safe, family-centred care, eliminate our deficit and begin to pay down our debt. The Ministry of Health responded by saying that a policy framework for such an agreement was not in place. Despite this, Rouge Valley persisted and by March of this year our deficit was eliminated. Given this history, we believe we have a somewhat unique perspective on Bill 8.

Let me be clear. Rouge Valley welcomes Bill 8 and the concept of entering into an accountability agreement with the Ministry of Health. We do, however, have some concerns with the way Bill 8 is being implemented, and we have outlined three suggested improvements to the legislation: (1) strengthen the process by which the Ministry of Health can impose accountability agreements; (2) move away from siloed accountability agreements with hospitals, community care access centres and long-term-care facilities and begin to embrace sector-wide accountability agreements that support the minister's vision of more integrated service delivery across sectors; (3) assist the OHA in its commitment to strengthen hospital and health system governance to prepare boards for the new world of performance agreements and competitive service-based funding allocations.

With regard to the first point, Rouge Valley Health System has specific concerns that relate to sections 22 and 26 of the act that allow the minister to issue compliance directives and compliance orders to Ontario hospitals. Rouge Valley understands the Ministry of Health is ultimately accountable for the quality, volume and price it pays for services provided by hospitals across Ontario. Given the wide variation in hospital capacities and historic levels of base funding, checks and balances must be in place to ensure that both hospitals and the Ministry of Health work in good faith to address disagreements which will arise when the Ministry of Health imposes an agreement under section 26.

Rouge Valley believes a commissioner or commissioners should be appointed under section 26 of the act when a hospital and the Ministry of Health fail to reach an accountability agreement following a compliance directive. We propose that a commissioner or commissioners investigate those circumstances and report back to both the Ministry of Health and the hospital board on the results of their review. Cabinet could then consider the commissioners' report and impose or modify the compliance order. Commissioners' reports must be public documents.

Minister Smitherman has made it clear, and rightly so, that he expects hospitals to focus on strengthening community understanding and support for necessary changes in health service delivery. As currently drafted, Bill 8 may well lead to compliance directives being imposed on hospitals behind closed doors without the opportunity for public involvement.

This dispute resolution process Rouge Valley proposes could also be put in place for community care access centres and long-term-care organizations to the extent that performance agreements are implemented in a variety of health sectors.

Those provisions in the act which allow the ministry to modify employment arrangements of CEOs must be removed. They violate the most basic principles of voluntary governance.

With regard to siloed agreements, last February Minister Smitherman said, "What's needed is better integration and planning at the local level so that we can deliver better results in each part of the province. Not a regionalized model, but a made-in-Ontario solution that builds on the strength of our community-based organizations, large and small."

Rouge Valley is an active member of several local groups committed to health service integration. In Durham, we participate in the Durham Region Health Care Group, chaired by the medical officer of health. Over the past few years, this group has worked diligently to improve palliative care and care for the frail elderly. We have also put in place joint approaches to encourage young people to choose health careers and coordinated our disaster and emergency response planning.

In the east GTA, Rouge Valley is an active member of the Toronto East Emergency Network. We are proud of the role we play in reducing emergency department bottlenecks and identifying ways that hospitals and other health care organizations can work effectively together.

The Ministry of Health should declare its intention to develop a policy and legislative framework to support accountability agreements with local health partnerships focused on improving services to defined populations. These agreements could supplement, and eventually replace, annual agreements with individual hospitals. This will lead to accountability plans with measurable targets for meeting health service delivery needs in local areas. In turn, this will encourage greater cooperation between health organizations and provide a mechanism to constructively involve the public in the design and monitoring of these agreements.

Rouge Valley Health System is working hard to engage the Scarborough and Durham communities in a process to determine how we can best respond to the growth, aging and extraordinary diversity of the communities we serve. We must develop better ways of delivering services with a focus on safe, family-centred care.

As currently drafted, Bill 8 is all about accountability up to the ministry, with insufficient attention to our accountability out to the communities we serve. As

previously suggested, making the commissioners' reports public will go a long way to correct this deficiency.

With respect to strengthening governance, no doubt committee members understand that significant disparities exist across Ontario and the GTA in hospital base budgets and in the ability of hospitals to access capital funding. Newer hospitals, built at a time when the provincial economy was strong, benefited from relatively generous base budgets. These facilities are further down the road to such things as electronic patient records and to achieving lower facility and energy management costs. Their cost per case is lower and they disproportionately benefit from the funding allocation formula developed by the joint policy and planning committee.

When it comes to capital funds, some high-growth municipalities, through previously collected development charges, are able to provide much more generous support for their local hospitals than others. For example, municipal hospital capital support in Durham lags far behind levels of support in Peel, York and Halton. Ministry of Health policy must change if we are to avoid the growing inequity in capital and operating funding between hospitals in municipalities that choose to support their hospitals and in those that are unwilling or unable to provide reasonable capital support in the absence of a change in government policy relating to development charges.

Rouge Valley anticipates that service-based funding will be the cornerstone of the new accountability agreements. While Rouge Valley is not proposing a delay in implementing Bill 8, we are asking the Ministry of Health to work with the Ontario Hospital Association to begin to correct these funding inequities before imposing accountability directives on individual hospitals.

It is also important to strengthen voluntary hospital governance. Hospitals like Rouge Valley are the meat in the sandwich between growing communities demanding improved access, often without regard to the need to live within our financial means, and the ministry's insistence—rightly so—on balanced budgets.

How can hospitals populate their boards with directors who bring strongly held stakeholder views to the table while ensuring board members understand the breach of their fiduciary duty of loyalty if they are to serve exclusively as an advocate of a particular community?

This is the kind of question that requires serious thought and action across Ontario. The Ministry of Health must move quickly to support the Ontario Hospital Association efforts to strengthen governance as we move forward with budgets allocated through service-based performance agreements rather than incremental adjustments to increasingly arbitrary base budgets.

Thank you for this opportunity to express our views on this landmark piece of legislation. We look forward to your questions.

The Chair: Thank you very much. We will have Mr Klees from the official opposition. We have five minutes remaining.

Mr Klees: You indicate that you don't propose delaying implementing Bill 8, yet you make some fairly strong arguments that there should be some significant amendments made. So I'm assuming that you don't mind the bill being implemented as long as they incorporate these amendments that you're proposing. Is that correct?

Ms Ramsay: That's correct.

Mr Klees: I'd like to just focus on the issue of accountability agreements.

You're used to dealing with the Ministry of Health; you know what kind of rapid response there is to the concerns that your hospital may have from time to time. With 150 hospitals, 43 CCACs and more than 500 nursing homes in the province, tell me, how practical is it that these accountability agreements can in fact actually be negotiated, signed off on, within the period of time that the Ministry of Health is proposing? And how many of those institutions do you think will immediately, the minute the gun goes off on this, actually be out of compliance?

1700

Ms Ramsay: I would agree with you in terms of the struggles the ministry has before it in negotiating agreements that are balanced from both sides with the resources they have, and I was interested in the remarks earlier. I think it will be a challenge, but perhaps if there are ranges or something that allows some flexibility in the agreements so that there is some flexibility from the hospital's point of view to operate within ranges and then from the ministry's point of view in terms of their guidelines, that would provide some room to not be out of compliance immediately.

Ms Martel: Thank you for being here. I'm interested in a bit of the background that you talked about on page 2, when you said that in 2002 you made a proposal to the ministry and the ministry responded by saying there was not such an agreement in place, and despite this you persisted. What was the experience and, given that experience, if you look at the wide range of agreements that now have to be negotiated, do you think the ministry has any capacity, or the appropriate capacity, to actually manage what's contained in the bill?

Ms Ramsay: I'm not sure I can comment on whether they have the appropriate capacity, but I'll give you a little insight into what we did. Hume Martin joined us in July 2002, when we were in a very difficult position. We were fortunate to hire Hay, which helped us with those benchmarking standards to create that service agreement. It did take a lot of work and effort, and I would suggest it will be a difficult task for every hospital to undertake the same sort of thing. But we did work through all of our programs, program by program, and looked at benchmark levels, how we related to those benchmark levels and where there were instances where we could save significant dollars. So there were areas where there were smaller differences, but we tackled the larger ones first, and that allowed us the great success.

It probably didn't take a lot of work for Hay—I mean, Hay's not in the room—to create the document. I think

what takes the work is getting the buy-in from your staff and from your physicians.

The Chair: We move to the government.

Ms Smith: Thank you both for being here today. I had a question about a comment you make under your accountability agreement section. At the very end of the third paragraph you say, "As currently drafted, Bill 8 may well lead to compliance directives being imposed on hospitals behind closed doors without the opportunity for public involvement." I just wondered if you had reviewed section 21.1 of the revised bill, because it provides for notice of non-compliance. It provides for a process of dispute resolution where the minister and the health resource providers discuss the circumstances that resulted in the non-compliance. There is an opportunity to exchange information and there's also an opportunity to post that information, to advise the public as to why a compliance directive is being issued. I just wonder why you would state that you think it could be imposed behind closed doors.

Mr Hume Martin: Our sense from reading the legislation is that if an agreement cannot be reached following all the steps that you just enunciated, it still could be imposed without any public explanation that would help to address the real issues that we face serving two very different communities, with expectations that may not be in line with the funding levels that are available. We want to make sure that if an agreement is imposed, it is public, so that the public is fully aware.

Ms Smith: How would the use of a commissioner in any way make this more public?

Mr Hume Martin: It would get around the issue that I think we've just spoken about, which is that there may not be the capacity in the Ministry of Health as currently structured to have as independent and objective a view as required in terms of these situations.

The Chair: Thank you for your presentation. I wish you a good evening.

COTA COMPREHENSIVE REHABILITATION AND MENTAL HEALTH SERVICES

The Chair: Next we have COTA, Comprehensive Rehabilitation and Mental Health Services. Welcome. You have 15 minutes for the presentation, and we will use any time remaining for question.

Ms Sandra Hanmer: Good afternoon, everyone. My name is Sandra Hanmer. I'm the president and CEO of COTA Comprehensive Rehabilitation and Mental Health Services. I'd like to thank you again for this opportunity to share our perspectives on Bill 8.

As many of you know, COTA is a leading not-for-profit community health and social service organization. We interact with all other parts of the health care system in Ontario. Our rehabilitation services are delivered through contracted partnerships with nine community care access centres across Ontario. We also deliver cost-effective site support, court support, hostel outreach, case

management and aftercare programs to individuals living with mental illnesses. These are all funded through the Ministries of Health and Long-Term Care, Community and Social Services, and Children and Youth Services.

We are pleased to see that numerous improvements have been made to Bill 8 since first reading. However, before I address some of our key points pertaining to each section, I'd like to highlight COTA's overriding concern with this particular piece of legislation. In its current state, we are still unclear as to how Bill 8 will impact our governance as a not-for-profit, community-based health provider.

COTA, in collaboration with our partners, performs a unique role in our health care system. As such, it is still not clear what definitions, as outlined in Bill 8, pertain to us. For example, are we to be considered a health systems organization? This is defined in section 1 as "any corporation ... that represents the interests of persons who are part of the health sector and whose main purpose is advocacy for the interests of those persons." Likewise, are we to be considered a designated practitioner? This is defined in section 7 as someone "who may not charge an amount for the provision of insured services rendered to an insured person other than the amount payable by the plan." Each of these definitions—either alone or in combination—could have significant implications for community-based organizations such as COTA. The most obvious one, clearly, is whether we are subject to accountability agreements with the ministry. We therefore urge the government to use clearly defined, consistent terminology to remove such ambiguities and ensure legislative compliance.

With respect to the preamble, CODA supports the inclusion of "community" as an integral component for collaboration within a strong health care system. We are also delighted to see the preamble now include a reference that our health system is to be governed and managed in a way "that reflects the public interest." However, we would like to see this expanded to include "timely access to care." It is in the best interests of the public to have access to health services and the system as a whole. However, if that access is not timely, it may not reflect what's in the best interests for the public.

While Bill 8 recognizes the recommendations put forth by the Romanow report—we commented on this before—it makes no mention of how these will be addressed. In order for our health system to remain relevant and function as a true system, it must encompass a full continuum of care, including community-based services. We therefore recommend that the preamble be amended to acknowledge the public's right to access home care and pharmacare within a publicly funded health system.

With respect to part I, the Ontario Health Quality Council, COTA fully supports the creation of a health quality council for Ontario. We are encouraged to see that our initial concern with restricted membership has been amended to allow participation by senior staff. Ideally, we would like to see this council comprised of all

key players in the health care system, such as patients, advocates, and health care providers, including the often-overlooked community health and support sector.

In his address to this committee, the minister highlighted the need for significant system-wide change to make medicare more responsive and focused on quality outcomes. The Ontario Health Quality Council, whose purpose is to track continuous quality improvement, is an important step in this direction. However, we would like to see the scope and function of the council expanded to enhance accessibility and accountability within our health care system.

For example, the council could report on the cost-effectiveness of programs, highlighting the cost-benefit of for-profit and not-for-profit delivery. In particular, we recommend a dedicated focus on the mental health sector.

COTA has over 30 years' experience delivering community-based care to individuals living with mental illnesses and evaluating the outcomes of our services. Organizations like ours could therefore offer a unique and necessary perspective on monitoring our health care system and recommending cost-effective solutions.

With respect to part II, health services accessibility, COTA is pleased that its concerns with privacy rights have been addressed in the amendments to section 13. We applaud the government for ensuring adherence to the proposed Bill 31 and removing the minister's authority to directly collect, use and disclose personal information.

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The government has recently reiterated its commitment for providing help to society's most vulnerable citizens. Indeed, the health minister claims that Bill 8 protects and promotes accessibility—the health care issue of most concern to Ontarians. However, there is currently no mention in Bill 8 of "access to care in the community," as outlined in the Public Hospitals Act. We recommend including this provision to underscore the government's commitment to health services accessibility throughout the entire health care system continuum.

We understand that the government may be considering reducing OHIP coverage to physiotherapy services. This would not only negatively impact our most vulnerable community members, such as seniors and people with disabilities, but it would reduce accessibility to a proven cost-effective service. Early physiotherapy intervention prevents chronic disabilities and will play an increasingly important role in health prevention as the baby boomer population ages. The ability to access rehabilitation services can make the difference between living independently in the community and becoming increasingly reliant on costly health care interventions. If the government is serious about enshrining accessibility through Bill 8, we respectfully urge the government to avoid considering such shortsighted cost-saving measures.

With respect to Part III, accountability, COTA supports the government's intent to strengthen the prin-

ciple of accountability within our health care system. We favour many of the changes that have already been made, particularly those amendments that ensure consideration of the "public interest" when enacting accountability provisions. We are also pleased with the amendments that will result in accountability agreements being made between the minister and board and not the CEO. Finally, COTA welcomes the proposed process for public involvement with regulations and requests that community-based stakeholders are included in these consultations.

The minister contends that accountability is a two-way street and that this legislation brings the notion of shared accountability to life. However, Bill 8 still appears to be largely a one-way street. There are numerous provisions to make health care providers more accountable to the government, but none that speak to how the government will meet its obligations of ensuring the provision of health care, particularly through stable, multi-year funding.

This point is particularly relevant for COTA. For the last several years, as an example, funding for the community health support sector has not been stable nor adequate and certainly not predictable. National research studies continue to provide evidence that home and community care is a cost-effective alternative to hospitals, nursing homes and emergency rooms. We therefore urge the government to revise the legislation to address the sustainability of the community support sector through stable, multi-year funding.

COTA also requests further clarification on how Bill 8 impacts governance. For example, the relationships that contracted service providers like COTA have with the various CCAC partners remain unclear. The bill is clear that the CCACs will be entering into accountability agreements. However, as a contracted partner, we would expect that our service agreements with the CCAC will reflect this accountability agreement and that we would not be entering into separate agreements with the ministry as a result. As I mentioned earlier, it is still unclear how that will play out.

Furthermore, COTA is also a transfer payment recipient. As mentioned earlier, will COTA be expected to enter into accountability agreements directly with the minister or will our current service agreements suffice? We urgently request the government to clarify explicitly how these contractual partnerships may be affected to ensure compliance.

In order to strengthen CEO accountability without undermining the role of voluntary boards, we also request clarification on the proposed lines of accountability between the minister and the board and the board and the CEO.

In conclusion, COTA fundamentally endorses the intent of Bill 8 to protect the defining values of medicare and to sustain its future for future generations. Significant improvements have already been made, but more remain if this legislation is to achieve its far-reaching objectives. We continue to seek amendments that ensure that both providers and the government are held accountable by Ontarians for the health care they receive.

Ontario is well positioned to include new ideas and models for health care whereby primary care, institutional care and community care all work together in a fully integrated, cost-effective system. We look forward to working collaboratively with the government to begin repositioning our health care system for the future.

Thank you for your time today.

The Chair: Thank you very much. We have about five and a half minutes remaining.

Ms Martel: Thank you for being here. On page 5 you say, "We ... urge the government to revise this legislation to address the sustainability ... through ... multi-year funding." Is that something you want to see directly in the bill, that the government is committed and there is an amendment that reflects that?

Ms Hanmer: That would certainly go a long way to ensuring that we do have that two-way accountability with the funding being in place.

Ms Martel: With respect to physiotherapy—I'm sorry, I should know this; I'm forgetting—does COTA also provide, through your rehabilitation, physiotherapy services directly or do you contract those?

Ms Hanmer: We provide physiotherapy services directly. We are not, however, an OHIP provider. We're not a schedule 5 provider, but we do have therapists who work in schedule 5.

Ms Martel: I know schedule 5 providers are lobbying the government very strongly, but is there anything you've heard outside of the schedule 5 that would lead you to believe there's going to be an impact on your direct services?

Ms Hanmer: Again, it's unclear. Depending on what happens with the schedule 5 therapy clinics, what's the impact on the rest of the community sector, what's the impact on CCACs in the provision of services in the home, as our therapists do provide services in individuals' homes, many of whom would be accessing or may be accessing the schedule 5.

Ms Martel: And then would have to look to you for that service?

Ms Hanmer: Yes, that's right.

Ms Martel: Is there a cost for your service now? Do you have a fee?

Ms Hanmer: We do have a fee for our service. Most of our services are provided through the community care access centres. We have a very small portion that's provided on a private pay basis. We do work with insurance companies as well, so whatever the fee for insurance companies is is what's paid to our providers.

The Chair: Thank you very much. Ms Smith?

Ms Smith: Ms Wynne has a question.

Ms Wynne: Thanks for coming in. I just wanted to clarify. You had some questions on the first page of your presentation in terms of how COTA would be affected. On whether you're a health system organization: You're not, because the main purpose of your organization, as we understand it, is the provision of service. So you wouldn't be considered a health service organization.

You asked about designated practitioners. They're defined in the Health Insurance Act and you're not

covered by that. The scenario you outlined whereby you have an agreement with the CCAC and the CCAC has the agreement with the ministry, that actually is accurate.

Ms Hanmer: Accurate.

Ms Wynne: Yes, OK?

Ms Hanmer: That's one example. But as Ms Martel was just asking me, we do have service providers who could be providing service directly to individuals outside of the CCAC environment. That's where we're not sure how we're fitting into the legislation. But I'm taking from your response that we probably don't.

Ms Wynne: You're not a health system organization, you're not a designated practitioner and you don't fall into the definition of a health resource provider in part III. OK?

Ms Hanmer: Thank you.

The Chair: Ms Witmer.

Mrs Witmer: Thank you very much. That's an excellent presentation. I guess now you know you're not covered by Bill 8—

Ms Hanmer: We're not covered by it.

Mrs Witmer: —according to Ms Wynne, so you won't need to be concerned about developing accountability agreements with the government.

But you do make some excellent points. You stressed the fact that despite what the government says, this bill really does not address the issue of providing timely access to care. You point out here the fact that the public should have the right to access home care and pharmacare within the system. How would you propose that would be included? You mentioned the preamble. Is there somewhere else where you would want to see that included?

Ms Hanmer: To me, that is an accountability portion as well, so in the appropriate sections within the accountability section of the act, so that again there is a two-way communication. The presentation prior to mine talked about the hospitals being integral components of their communities. We too have to be working with all sectors. The legislation has to reflect not only the institutions but also the community portion. The preamble would be a portion of that, as well as the accountability.

Mrs Witmer: You mention the fact that Bill 8 makes no mention of access to care in the community, as outlined in the Public Hospitals Act. I would certainly agree with you. I think that's a real deficit in this legislation. Any claims that have been made that this is going to protect and promote accessibility, we don't see that as the bill is currently written. I trust the government will hear the voices of concern.

Thank you very much. As I say, I think you've reiterated the main issues of concern that we've heard from all of the presenters, but a great presentation.

Welcome. You have 15 minutes for the presentation and there will be questions, should there be time remaining.

M. Normand Fortier: Je me présente. Mon nom est Normand Fortier. Je suis le président du Réseau des services de santé en français de l'Est de l'Ontario. Je suis accompagné de M^{me} Nicole Robert, qui est la vice-présidente du Réseau, mais elle est aussi membre du conseil d'administration de l'Hôpital Montfort.

Monsieur le Président, permettez-moi d'abord de vous remercier d'avoir accordé au Réseau des services de santé en français de l'Est de l'Ontario l'occasion de faire une intervention devant vous aujourd'hui sur la question de la Loi 8. Nous savons fort bien que votre temps est précieux et que votre tâche est pressante. Vous comprendrez qu'il en est de même pour nous.

Notre réseau oeuvre au service du mieux-être du quart de million de francophones de l'est de l'Ontario. Il est composé d'une soixantaine de membres, dont les établissements hospitaliers de la région.

Nous avons suivi avec intérêt le débat entourant la Loi 8. Nous tenons à féliciter le ministère de la Santé et des Soins de longue durée et les membres du comité qui ont proposé et accepté d'inclure les amendements au texte de la loi. Deux de ces amendements sont extrêmement importants pour la communauté franco-ontarienne.

D'abord, l'abolition de toute amende envers les bénévoles qui acceptent d'être membres des conseils d'administration d'hôpitaux. Il s'agit là d'une sage décision.

Le deuxième changement porte sur la décision du ministre d'inclure dans la Loi 8 qu'il agirait « dans l'intérêt public ». C'était une question capitale pour la francophonie ontarienne. Nous n'avons jamais douté que le ministre Smitherman n'oserait jamais agir contre l'intérêt public. Mais pour tout dire, nous avons été intrigués par le fait que cet aspect soit exclu de la loi.

Le Réseau et les établissements et organismes francophones de santé qu'il regroupe sont tout à fait d'accord avec la notion d'imputabilité qui, de toute évidence, est au cœur de la Loi 8.

Le Réseau et ses membres se doivent d'être imputables. Nous n'avons aucune marge de manœuvre pour utiliser des fonds gouvernementaux à mauvais escient. Nous sommes redoublés à notre communauté et les attentes de celle-ci sont, à juste titre, élevées. Nous sommes des gens responsables.

En Ontario français, nous avons eu à assumer nos responsabilités et, plus souvent qu'à notre tour, à demeurer vigilant afin de préserver nos acquis.

Vous n'êtes pas sans connaître les circonstances entourant l'épisode de l'Hôpital Montfort. Bien qu'il ait été concluant pour les services de santé en français dans la région de l'est ontarien et pour la communauté franco-ontarienne, c'est un scénario que nous voulons éviter à tout prix.

Monsieur le Président, membres du comité, c'est de cette vigilance que nous faisons preuve aujourd'hui.

La communauté franco-ontarienne est plus que prête à participer au développement de notre système de santé.

Elle le fait déjà dans l'est ontarien, grâce aux centaines de professionnels de la santé qui travaillent activement à l'offre des services de santé en français et grâce aux gestionnaires des établissements pour qui l'amélioration de l'accès aux services de santé de qualité en français à la population francophone est une priorité.

Dans cette perspective, nous sommes ici aujourd'hui pour vous faire part de sérieuses préoccupations avec le contenu de la loi tel que présenté en deuxième lecture.

Our serious preoccupations with Bill 8 have to do with the new powers of intervention the minister seems to be giving himself over hospital CEOs.

First, let us signify that we fail to understand how certain individuals can be singled out and targeted in such a way within the entire government system to take the blame for failed policy. Let us also say that it is perceived as a non-confidence vote against every board of trustees of every hospital in Ontario.

We are not here as legal experts. But as francophones we have, sadly, had to go through more court cases than we can count. And there is one thing we did learn from our justice system: No government is above the law. You can't pass any law you want simply because it appears convenient at the time.

In this sense we deem that Bill 8's singling out of CEOs is a question of fundamental justice. And it is not right. But from our Franco-Ontarian point of view, there are greater concerns that go to the very heart of continuing fostering and survival as the most populous linguistic minority and one of the founding peoples of this country.

In our world, as a minority, institutions are something we consider sacred, because they are our only chance of survival. It is true of our schools, of our community colleges, of our justice system where lawyers represent us in our language, and it is certainly true of our health care institutions.

As a community, we're keeping a close eye on the development of our system. In that sense, we are greatly concerned that as Bill 8 still stands, our board of trustees' authority could be suddenly undercut and the CEO of our only francophone teaching hospital would be the chosen target of the minister, on the advice of his bureaucrats.

The fear of retribution is something we find extremely hard to accept, because the CEO of Montfort is in a unique position, as are other administrators tending to the health needs of the francophone population. On a daily basis they have to make decisions that are not only based on health care formulas but also on the assurance that the linguistic, the cultural and, in the case of Montfort, the French academic mandate of the hospital will be respected. This is a responsibility that makes the CEO an integral part of the governance of the establishment, and should he not assume it, he would not be there.

Negotiating for Franco-Ontarian rights with the government of this province has at times proven arduous. Yes, we will sometimes find a sympathetic ear at the political level, but it is quite different when you are confronted with the bureaucratic formulas that do not

factor in francophones and that impose accountability that we are ready to provide and have always provided, but is rarely asked from other organizations.

When you elevate that problem to that of the Montfort governance, which has too often come up against departmental incomprehension when all it is doing is pleading for basically essential service of the Franco-Ontarian community, then perhaps you can understand that we feel we are, as a minority linguistic community, being put in an extremely vulnerable position.

The Réseau does not represent Montfort Hospital only. Its many stakeholders all seek to improve their services to the francophone population, but the truth is that without Montfort's strong example and leadership, a lot of these efforts will be lost. Montfort is an excellent example of what is possible in terms of an extremely well-performing institution that is perfectly adapted to its community.

Mr Chairman, members of the committee, we sincerely believe that the members of our numerous boards of trustees can achieve in terms of accountability what the minister wants to achieve. It is now a matter of mutual trust, not of confrontation.

In the case of francophone rights, we are greatly concerned that the CEOs of our hospitals could be exposed to severe penalties as Bill 8 stands today.

À notre humble avis, une telle intervention du gouvernement dans notre système de gouvernance irait à l'encontre de tous les principes que les cours de justice du Canada ont énoncés maintenant depuis deux décennies. La majorité de ces jugements touchent le domaine de l'éducation, ainsi que l'article 23 de la Charte canadienne des droits et libertés. Toutefois, ils ont été cités abondamment dans l'argumentation qu'a présentée la Cour d'appel de l'Ontario pour rendre sa décision historique envers Montfort, centre de formation national pour les professionnels de la santé en français.

Il est aussi utile de se rappeler les dispositions de la Loi sur les services en français de l'Ontario, l'autre Loi 8. Dans le jugement de Montfort, la Loi sur les services en français, associée au principe constitutionnel de la protection et du respect des minorités, a pleine force de loi. Il s'agit en fait d'une loi quasi-constitutionnelle. Même les procureurs de la Couronne étaient d'accord avec la Cour d'appel sur ce point. Permettez-moi donc de vous citer un extrait du paragraphe 162 du jugement de la Cour d'appel que nous croyons très pertinent au débat actuel:

« La désignation de Montfort en vertu de la Loi sur les services en français inclut non seulement le droit aux services de santé en français, mais aussi le droit à toute structure nécessaire assurant la prestation de ces services en français. Cela comprend la formation des professionnels de la santé en français. Interpréter la loi de toute autre manière, c'est lui donner une interprétation étroite, littérale, limitée, par opposition à une interprétation qui reconnaît et traduit l'intention du législateur. »

Mr Chairman, when the French Language Services Act, as quoted by the Ontario Court of Appeal, speaks of

all the necessary structures to render a francophone institution truly francophone, it necessarily includes governance, and that governance is not just limited to the board of trustees but to all those within the administration who are entrusted to exceed, to go beyond the standards of excellence simply to prove they have a right to exist. It is our understanding that when it comes to minority rights, Bill 8 as it stands could contravene successive court judgments in the last two decades.

1730

We come here as friends of the government of Ontario, of the members of this committee and of this Legislature. The Réseau's presence today serves one purpose, and that is to further the understanding of the impact that Bill 8 could have on our community. In the name of the responsible governance within the community and with respect to the rights of French-speaking Ontarians in Ontario, we trust you will consider our submission. Merci.

The Chair: Merci. We have four minutes remaining.

M^{me} Smith: Merci, monsieur Fortier et madame Robert. On apprécie bien votre présentation aujourd'hui. Au sujet de votre composition: vous avez une soixantaine de membres dans votre Réseau, et je me demandais, avez-vous d'autres fournisseurs de ressources en santé? Est-ce que vous représentez d'autres fournisseurs de ressources en santé?

M^{me} Nicole Robert: Tous les membres de l'organisme, du Réseau, sont des fournisseurs de services en santé. Les membres du Réseau dont vous comptez 60 comprennent tous les hôpitaux d'Ottawa et dans les régions de l'est. Vous avez les hôpitaux de Renfrew, de Cornwall, et dans la région de Hawkesbury et toute la région d'Ottawa. Nous comptons également toutes les institutions éducatives qui donnent des services d'éducation pour les professionnels de la santé, donc pour les infirmières, pour les orthophonistes, cervothérapeutes et physiothérapeutes, et tous les organismes de santé communautaire, dont mon organisme également en santé mentale, donc les organismes qui offrent des services de santé dans la région.

Nous comptons aussi des représentants du CASC d'Ottawa et de la région de l'est ainsi que de la région de Renfrew. Donc ça rencontre tous les organismes de santé que nous pouvons rencontrer et qui offrent des services en français.

Mr Klees: Thank you very much for your presentation. I recall when we met in Ottawa, where our former colleague M. Grandmaître made quite a passionate speech. In fact, he went to the extent of saying, if I recall his words, "This is not the Liberal Party that I signed on to." He was very strong in his condemnation of this bill. You are no less passionate in terms of your condemnation. In fact, if I read between the lines, and it doesn't have to be too much between the lines, I hear you saying that this bill effectively, when it comes to minority rights, is an unconstitutional piece of legislation.

Have you had legal advice? Do you have a legal opinion relating to this particular piece of legislation and

that issue in the context of the successive court judgments to which you refer?

Mr Fortier: Nicole will answer, but in the case of le Réseau, we don't have that many dollars to invest. We're going to wait until the legislation is passed and then we'll react. There's no way we can afford to look at the document unless it's complete.

Mr Klees: But I assume if it is passed without amendment, that is your position, that you will challenge it on a legal basis.

Mr Fortier: We'll certainly ask for legal advice, yes.

Ms Robert: As the board of the Montfort Hospital, as you've seen, we've been through many court cases. I was part of the board at that time also.

Definitely the document as it stands needs amendment, and I think the government is listening to all our sessions because the amendments are important for all the hospitals of Ontario. So I think we'll have to wait until the amendments and the law are passed to determine that, but there are many amendments that have been looked at and this is another important one that we're bringing forward.

M^{me} Martel: Merci d'être venus cet après-midi. J'ai une question pour vous, madame Robert, dans votre capacité de membre du conseil de Montfort. Durant la deuxième lecture, j'ai rencontré une partie des présentations de M. Grandmaître et de M^{me} de Courville Nicol. Après mon discours en deuxième lecture, M. le ministre Smitherman a dit qu'il avait parlé avec M. Grandmaître et qu'il n'existant plus de « concerns » de sa part.

Mais vous êtes ici en tant que membre du conseil de Montfort. J'ai lu la présentation, et à mon avis il existe encore des concerns de la part du conseil de Montfort. Est-ce que vous pouvez dire oui ou non, des concerns existent encore avec la deuxième présentation du projet de loi 8, et est-ce que vous pouvez exprimer clairement les concerns?

M^{me} Robert: Selon le document que nous avons présenté aujourd'hui, l'importance ici est celle d'un président et directeur d'un hôpital d'avoir quand même la possibilité de prendre les décisions de jour à jour de la fonction et de la gestion d'un hôpital grâce à son mandat et suite aussi aux responsabilités et l'imputabilité qu'il reçoit de son conseil d'administration. C'est ça notre souci aujourd'hui. C'est que le président-directeur général d'une institution, pas seulement Montfort, puisse pouvoir prendre des décisions de gestion comme un gestionnaire doit le faire. C'est ça notre souci aujourd'hui.

The Chair: Thank you very much. Merci beaucoup pour la présentation, et bonsoir.

M^{me} Robert: Merci beaucoup pour nous avoir reçus.

GREY AND BRUCE COUNTIES

The Chair: Next we have the Grey and Bruce counties community presentation. I'd like to welcome you. You will have 15 minutes for your presentation. Once

again we'll split questions and answers for any remaining time between the parties. Welcome.

Ms Sonya Mount: My name is Sonya Mount. I'm the past president of the Grey Bruce Regional Health Centre Foundation. With me tonight is Ernie Morel, who is the current chair of the Walkerton and District Health Services Foundation.

What we want to do this evening is to take you someplace different. We want to take you to Grey and Bruce counties, and we want to give you a virtual tour of Grey and Bruce counties and health care in rural Ontario. I know some of the members of this committee are quite familiar with rural Ontario and some of you are not, so let's go for a quick tour. That's what we're going to try to do.

We're also going to try to point out to you the impact of Bill 8 as it sits with us today and what will happen to Ernie and me and our foundations if this bill is passed as it currently sits.

Grey and Bruce counties are very sparsely populated. We have the highest seniors population in Ontario. We have heart disease and incidence of stroke higher than all of the provincial averages. We have access to tertiary care which is a challenge. You should try getting to London in the middle of a snowstorm in January.

Rural Ontarians have a poorer health status than their urban counterparts. That was pointed out a number of times within the Romanow report. Recruitment and retention of health professionals is a top priority and a very significant challenge. Grey Bruce Health Services, which is supposed to be the regional centre for two counties as well as outside areas, has the second-lowest number of specialists in Canada servicing that community.

Right now in Grey and Bruce counties there are 10 foundations. There are over 100 members of the foundation boards and the directors, and they commit thousands of hours to their board work and to actual fundraising events.

When we have a special fundraising campaign, we use huge numbers of volunteers. With the recent CT scan campaign in Walkerton and the current MRI campaign that is underway in Owen Sound, we're sitting at about 350 volunteers as it sits today. Those numbers, as the MRI progresses, will increase, as well as the other regional asks that are out there right now. Those are huge numbers of volunteers. Right now, volunteers within the two counties are committed to raise \$48 million in capital campaigns in Grey and Bruce counties.

What happens when you are a CEO in Grey or Bruce county? Our current CEOs are very accountable. The formal accountability structure sits between the CEO and their local board. In Grey and Bruce counties, the CEO is the face of rural health care. When you're a CEO in the GTA and the numbers are produced on what your income is over \$100,000, for most of the people in this area it's not even on the radar. If you're a CEO in Grey and Bruce counties, chances are you're going to hear about it in the grocery store, you're going to hear about it at church and

you're going to hear about it at your kid's hockey game, because everybody knows your face, everybody knows who you are and everybody knows exactly how much money you make. There is no place for a CEO in rural Ontario to hide. When they make a recommendation to a board about beds, about facilities, or about anything else that exists within their facility, they will have to bear the brunt of that, and they will bear it face to face as they go through their community.

1740

The way we sit today, most rural Ontarians have no idea what Bill 8 is about. They have no idea of how it will impact them. Most rural Ontarians want accountability from their hospitals and from their government on how their health care is delivered. There is a lot more to accountability than dollars and cents. There's an expectation that their boards and their CEOs will make those decisions on moral and social responsibilities, and those decisions are made to their neighbours, their staff and their communities.

Rural Ontarians are fiercely loyal to their hospitals—if any of you can remember what it was like when there were some discussions about closing rural hospitals. We generally have poor access to health care, but our people are generous supporters of our foundations. They support the campaigns because they know who to hold accountable when the care and equipment they need is not there.

After Bill 8, what we're envisioning is hospital boards forced to sign accountability agreements. Given the number of hospital corporations within the province, it is virtually certain that the content of these agreements will not be sensitive to the needs of rural Ontario. The common buzzword is "legislation south of 7." It used to be "south of 2," but they've moved it up to "south of 7."

Rural Ontarians will hold their government, not their local boards or their CEOs, accountable for the programs and services that rural hospitals can no longer provide. In this environment, it will be impossible for rural hospitals to recruit board members for their hospital or for the foundations. Further, the joint initiatives that rural communities undertake collectively are discouraged under this legislation. We raise money based on trust. The trust is that the money is used wisely, that the dollars for the equipment and programs will go to programs whose future is secure. Rural Ontarians have little trust in remote bureaucrats to make the right decisions about the health care they currently need.

With hospital boards losing their ability to determine and respond to local health care needs, the generosity of rural communities to support their local hospitals and the volunteers who raise those funds will evaporate. The current financial impact of modernization and capacity expansion in Ontario is set between \$7 billion and \$9 billion. Right now, within Grey and Bruce county, we have substantial needs for major building redevelopment. If the 50% share that the rural community is expected to raise evaporates, the long-term implication on the taxpayer will be huge.

So what do we want you to remember? This committee is subject to a number of presentations. What we would like you to do by not addressing a specific paragraph or clause is that, when you're reviewing this Bill 8 and all of the components that it contains, remember that rural Ontarians are entitled to equal access to health care. Remember that the responsibility for local determination of health care needs remains with local volunteer hospital boards. Remember that hospital foundations can maintain the trust of their donors in the sustainability of rural health care, if we can have the bill worded that way. Thank you very much.

The Chair: Thank you for your presentation. We have seven minutes remaining. We will start with the official opposition.

Mrs Witmer: Thank you very much for your presentation. I think you have been able to accurately describe what health care and hospital boards in rural Ontario see as important. They do play a very critical role. I think you've also been able to successfully point out that, without some preliminary steps to be taken by the Ministry of Health such as ensuring equal funding for all hospitals across the province of Ontario, ensuring that there's equal access to care across the province, it really would be premature to move forward with these accountability agreements about which we don't know a lot. In fact, we don't know how they're going to relate to the accountability frameworks that have been developed, or are in the process of being developed, by the JPPC.

One of the suggestions that's been made is that because of so many unknowns and because of the uneven playing field in the province today, it would be wise to put in place some pilot accountability agreements. Would you be supportive, for example, of perhaps taking a hospital in rural Ontario, taking a long-term-care facility, to see if indeed these new agreements are going to be responsive and meet the needs of people throughout the province? Have you thought about how these would be implemented?

Ms Mount: The pilot project?

Mrs Witmer: A pilot project, which means you don't negotiate accountability agreements for every one of the providers—all the hospitals, all the long-term-care facilities and anything else that comes under it—but you would begin, perhaps in year one, to negotiate accountability agreements that would reflect a cross-section of those that are going to be part of the accountability agreement so you can determine whether the framework the ministry is thinking about is appropriate to meet the unique needs of, for example, rural hospitals or long-term-care facilities or city hospitals.

Mr Ernie Morel: Sure. We'd be happy to be part of a test, provided it was clearly understood that that's exactly what it is, a test.

Ms Martel: Thank you for being here this afternoon. Ms Mount, you've spoken very passionately of your concerns about how the bill will impact rural Ontario. Tell me, what would need to be done to this bill so we would not see CEOs put at risk by the minister being able

to claw back compensation and take other action against them, and also so we would not be in a position where volunteer board members would just make a decision not to be part of their local board because they weren't interested in being party to something essentially being run out of Queen's Park? What changes have to be made to this bill to stop those things from happening?

Ms Mount: From my reading of the bill, with the way it is currently worded the accountability contracts have very little flexibility. You can't have responsibility without accountability. The CEOs and the boards would have to know it was a one-on-one, a specific accountability contract that met their need and their community's. We're talking Grey and Bruce counties. Let's go to North Bay, to Little Current—no different in those communities than where we are. Their CEOs have the same issues that ours do, and they would have to be made aware, as would the boards, that they could deal with those contracts, that there was a mechanism by which they could appeal them and could appeal the final results.

Ms Wynne: Thank you very much for coming and for your presentation. I just want to challenge a couple of the assumptions and ask you where they come from.

You make the statement that "the joint initiatives that rural communities undertake collectively are discouraged under this legislation." How are they discouraged? You're saying that they're actively discouraged, and I don't understand where you're getting that.

Ms Mount: The bill makes reference to payment from hospitals to outside groups and outside suppliers. In our community we currently run a rehab program, a pilot program, in conjunction with the local Y. My read of the bill does not allow for that kind of payment, out of funding, to the local Y to help with that program.

Ms Wynne: I will have to check that.

Ms Mount: When I read it, that's the way I read it.

Ms Wynne: OK. That links back to the other issue about the virtual certainty that the content of the agreements will not be sensitive to the needs of rural Ontario. The negotiated nature of the agreements—to my mind, the reason the negotiation has to happen is that each hospital and each organization is different, so there has to be a conversation between the ministry and the organization to make sure the accountability agreement fits the situation. I would guarantee that people in my riding in Toronto don't know about Bill 8 either and people in the hospitals in Toronto think they have unique situations too. That's my understanding of why they have to be negotiated, so why the certainty?

1750

Mr Morel: My reading of the proposed legislation is that it doesn't provide for much negotiation. It appears that it's going to be mandated to the boards.

Ms Wynne: Sixty days of negotiation, OK? It's only after those 60 days that there's then a 30-day period where there's a process, and at the end of that, there could be the imposition of an agreement. But there are 60 days of negotiation. That's why that's there.

The Chair: Thank you. We'll have to stop there. Unfortunately, time has run out. Thank you very much for your presentation. Have a good evening.

INSTITUTE FOR CLINICAL EVALUATIVE SCIENCES

The Chair: Next we have the Institute for Clinical Evaluative Sciences. Welcome.

Dr Andreas Laupacis: Thank you. I think I'm the last person.

The Chair: Yes. You have 15 minutes. Should you not require the 15, we'll use it for questions.

Dr Laupacis: Great.

Good afternoon. I'm Andreas Laupacis, the president and CEO of the Institute for Clinical Evaluative Sciences, more commonly known as ICES. On behalf of our board of directors, I'd like to thank you for giving us the opportunity to be here.

ICES is an independent, non-profit organization that produces unbiased knowledge on a broad range of health care issues to enhance the effectiveness of health care for Ontarians. Our information is used by governments and providers to support health policy development and changes to the organization and delivery of health services.

My remarks today will be restricted to part I of Bill 8, the Ontario Health Quality Council. Let me begin by congratulating Minister Smitherman and the McGuinty government for tabling a bill that would see the creation of a health quality council in Ontario. A body of this nature has been discussed repeatedly in Ontario over the years but has never come to fruition. It is much needed and long overdue. With health care expenditures now accounting for 46% of the provincial budget, Ontarians are entitled to know what they are getting for their investment. The creation of a body composed of independent, objective individuals to monitor and report on health system performance is a positive step toward public accountability, improved quality and better management of a more coordinated health care system.

I'd like to focus my remarks on three aspects important to the quality council, first, the current lack of readily accessible, high-quality information needed for the council to fulfill its mandate; second, the need for the council to actively support the development and use of evidence-based guidelines and standards; and third, the importance of local and regional quality improvement initiatives, which I think is what we heard in the presentation preceding mine.

Bill 8 identifies the functions of the council as monitoring and reporting on access to services, health human resources, population health status and outcomes, and supporting continuous quality improvement. Regarding section 4(a) and its components, the critical challenge for the council will be to fulfill its responsibilities in the current absence of the necessary information or data.

In my opinion, Ontario has fallen well behind other jurisdictions in terms of the data available to monitor

health system performance. For example, the public is concerned about access to MRI scans, but the data needed to accurately determine wait times is not currently available. As well, the information required to answer the question, "Why are Ontarians waiting for MRIs and other key services?" is not being collected systematically.

Last year, ICES released one of the most comprehensive reports available on the management and outcome of diabetes, a chronic disorder of epidemic proportion in North America. One of the cornerstones of high-quality management of people with diabetes is good blood sugar control with diet and medications. However, we were unable to report on the quality of blood sugar control in Ontario because the results of lab tests are not being captured in a central repository.

Veterans Affairs in the United States recently described their impressive quality improvement initiatives in the New England Journal of Medicine. They reported on 17 important indicators of quality. Right now in Ontario, we can only report on six of these. Currently, Ontario simply does not have the information necessary to effectively monitor and report to the public on how the health system is performing. A concerted effort is urgently needed to correct this deficiency.

In most cases, the data is being collected but not brought together. Centrally housing much of this information would not be a difficult undertaking but rather would entail changes to existing processes. The benefits in terms of health system monitoring and reporting would be worth the time and investment.

With regard to section 4(b), the council's function in supporting continuous quality improvement, ICES agrees that this is a critical role, a role that could be strengthened by articulating the manner in which this responsibility will be fulfilled.

Stating that the quality improvement will be supported by council, without identifying the specifics regarding the manner in which this will occur, is too vague and runs the risk that substantive and necessary changes will not be made broadly or consistently.

We suggest adding the following items under clause 4(b), so that it reads:

"The functions of the council are ... to support continuous quality improvement, including,

"(i) ensuring the development of evidence-based guidelines and standards in health care delivery that provide information on the use of new and existing treatment options and identify outdated or ineffective treatments,

"(ii) promoting the practice of evidence-based guidelines and standards to professionals across the province through broad and effective methods of communication."

The inclusion of these items under clause 4(b) is critically important in arming clinicians with the necessary information to maximize the effectiveness and consistency of health care delivery across Ontario.

In Canada, we are seeing the creation of a variety of quality councils, including a national council, and one in Ontario focused on cancer. It is important that the work

of these councils not be duplicative or contradictory. In general, it is local information that has the most impact upon the delivery of care. Thus, our provincial quality council must not be seen as replicating the quality initiatives of hospitals, local area networks or others. The data needed to monitor health at the provincial level, currently lacking, must also be provided at the local level to enable improvements.

In summary, the creation of a health quality council in Ontario is a significant and positive step forward. For this body to be successful in discharging its responsibilities, immediate action needs to be taken to address the current data deficit, evidence-based practices need to be identified, profiled and promoted province-wide, and the council must be supportive of local quality improvement initiatives.

We look forward to working with the government and council in making the necessary progress. With over 50 investigators, many of whom are practising clinicians, ICES has expertise in all areas of health care delivery, has a distinguished track record of producing usable knowledge out of raw health care data, and is eager to help the council fulfill its mandate. Thanks for your time.

The Chair: Thank you very much for your presentation. We have eight minutes remaining. We will start with the third party.

Ms Martel: Thank you for being here today. I've taken the position that we may have great people on the council, but given their limited capacity to make recommendations, they won't be able to hold the government accountable.

In the section right now with respect to what they're able to do, the most they're able to do is make recommendations about a future area of reporting. They may well go out and get great information regarding access to MRI scans, but if they can't make recommendations about funding to improve that, then you have a great deal of information and a ministry doing nothing with it.

I have consistently made the point that the council should have the ability to make recommendations to the minister about what they gather, specifically recommendations on funding, on changes to health policy, and even on changes to health legislation. I'm wondering if you can comment on that.

Dr Laupacis: There is obviously a line between an independent group that may not have all the information the minister has at his disposal and a group that actually has to make decisions. But I certainly agree with you that the quality council should be able to clearly identify where there are areas of deficiency and perhaps provide policy options. That might be one way I would go, where one could say, "On the basis of the information we have seen, here are some reasonable policy options for the government to consider in order to improve the quality of care."

Ms Martel: And those should be public.

Dr Laupacis: I would agree.

Ms Smith: We appreciate your being here today and your input. I was wondering if you could tell us, do you see a role for district health councils in providing that

local information that you spoke about in the latter part of your presentation?

Dr Laupacis: I sure do. I see a role for all sorts of individuals throughout the health care system. I happen to have the pleasure of sitting on the quality council for cancer in Ontario, and the way that council operates is to broadly solicit information from all individuals—patients, practitioners, hospitals etc—to identify what they think the most important quality indicators are. I would have thought that district health councils would have a very active role to play in that.

Obviously, you don't want to collect so many indicators that it becomes overwhelming, and at some point a quality council like this will have to decide they want some indicators that look at prevention, at acute care and at palliative care etc. But absolutely, I think DHCs would have an important role in feeding suggestions and information up to that quality council.

My comment about data and information, though, is that I think it's important that those data are available province-wide.

Mrs Witmer: Thank you very much for your presentation. As Minister of Health, I certainly appreciated

the tremendous data that ICES was able to collect and, hopefully, we were able to put to some good use.

I share the concerns of Ms Martel. Number one, this council is not going to be independent—I do believe that—and it was promised it would be. Secondly, it will not be in a position where it can make recommendations. I agree that, using the data that has been collected, they should be in a position where they can make recommendations on policy and funding, whether it be options or what. I believe the main deficit in the council is the fact that it's not independent and it has no capacity to make any recommendations as to where we go in the future. You've got all this data, but you can't recommend as to how it could be used to help better the quality of care in the province.

The Chair: Thank you very much for your presentation. We wish you a good evening.

For the committee, thank you for your patience in this heat today. We will adjourn until tomorrow, May 11, at 4 pm.

The committee adjourned at 1802.

STANDING COMMITTEE ON JUSTICE AND SOCIAL POLICY

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**Legislative Assembly
of Ontario**

First Session, 38th Parliament

**Official Report
of Debates
(Hansard)**

Tuesday 11 May 2004

Standing committee on
justice and social policy

Commitment to the Future
of Medicare Act, 2004

Chair: Jim Brownell
Clerk: Susan Sourial

**Assemblée législative
de l'Ontario**

Première session, 38^e législature

**Journal
des débats
(Hansard)**

Mardi 11 mai 2004

Comité permanent de la
justice et des affaires sociales

Loi de 2004 sur l'engagement
d'assurer l'avenir
de l'assurance-santé



Président : Jim Brownell
Greffière : Susan Sourial

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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON
JUSTICE AND SOCIAL POLICY

Tuesday 11 May 2004

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

COMITÉ PERMANENT DE LA JUSTICE
ET DES AFFAIRES SOCIALES

Mardi 11 mai 2004

*The committee met at 1602 in room 151.*COMMITMENT TO THE FUTURE
OF MEDICARE ACT, 2004
LOI DE 2004 SUR L'ENGAGEMENT
D'ASSURER L'AVENIR
DE L'ASSURANCE-SANTÉ

Consideration of Bill 8, An Act to establish the Ontario Health Quality Council, to enact new legislation concerning health service accessibility and repeal the Health Care Accessibility Act, to provide for accountability in the health service sector, and to amend the Health Insurance Act / Projet de loi 8, Loi créant le Conseil ontarien de la qualité des services de santé, édictant une nouvelle loi relative à l'accessibilité aux services de santé et abrogeant la Loi sur l'accessibilité aux services de santé, prévoyant l'imputabilité du secteur des services de santé et modifiant la Loi sur l'assurance-santé.

HALTON HEALTHCARE SERVICES

The Chair (Mr Jim Brownell): I call the committee hearings to order. I'd like to welcome the committee. First on the agenda, we have the Halton Healthcare Services. A 15-minute time period, and should you not require the full time for your presentation, we'll have question period at the end. Welcome.

Mr Shavak Madon: Thank you. Mr Chairman and members of the committee on justice and social policy, I would like to begin by once again thanking you for the opportunity of being here today. My name is Shavak Madon. I'm the chair of the board of directors for Halton Healthcare Services, representing Oakville-Trafalgar Memorial Hospital and Milton District Hospital. Joining me here today is Barbara Burton, our past chair.

We had the privilege of presenting to you in February, and we are pleased to be here again today. We congratulate you on the process you have undertaken. Your commitment to these hearings and your willingness to again listen to stakeholders and consider public input are commendable.

The board of Halton Healthcare Services supports the overarching principles of Bill 8. We are encouraged by the progress that has been made, but we still have a number of fundamental concerns.

We continue to believe that Bill 8 is a work in progress. We are still hopeful that the components of the bill will evolve to a point where the government, health care providers and, most importantly, the residents of our communities who rely on us for health care services will benefit from the fundamental principles this bill is based upon.

As we stated before, we support the key provisions of Bill 8, including establishment of the health quality council, embracing the five key principles of the Canada Health Act, adding accountability as the sixth principle, and thereby strengthening the provisions governing medicare.

Our first comments relate to section 9 and the provisions regarding physician payments. In February, the bill appeared to be too restrictive regarding physician payments by the hospital. Now the bill seems to allow for any type of payment to a physician by the hospital. This really concerns us. There is no black and white answer or solution to this issue.

The board is not properly positioned or equipped to effectively decide upon a continuum of ongoing requests for enhanced payments beyond the provincial standards. It should only be in rare and unique circumstances that physicians should be entitled to approach the board to seek additional payments. Given that physician payments are currently being addressed by the Ministry of Health and Long-Term Care, the Ontario Hospital Association and the Ontario Medical Association, we recommend that this complex matter be completely removed from the legislation.

Bill 8 continues to cause us concern regarding governance issues pertaining to the development of accountability agreements. We support enhanced accountability, including the development of negotiated accountability agreements between the government and hospital boards. While we are pleased that the bill now identifies the need to negotiate, we are very concerned that the government continues to have the power to impose agreements if they are not agreed upon within a 60-day period.

The process of negotiation allows for the community's voice to be heard and creates a sense of ownership and trust. This is lost if boards are forced to sign accountability agreements that do not fully recognize the needs of their community. The imposition of accountability agreements undermines local voluntary governance and silences the voice of our two communities. It removes the ultimate authority for determining service availability

and restrictions from the agendas of our board of directors and replaces it with a centralized provincial process. We should be striving for a more collaborative process, based on a relationship of mutual trust and respect, so the result is both fair and realistic and ultimately responsive to our stakeholders' needs.

One of the lessons we can learn from the BC Auditor General's report is that the process for establishing agreements should not be rushed. Enough time should be allowed for full collaboration between the negotiating parties to ensure local community and governmental needs are met. We support the Ontario Hospital Association's recommendation that accountability agreement disputes be referred to a neutral third party for resolution. This will ensure an open, democratic process of negotiation, which will result in a fair resolution that will ultimately be more conducive to achieving the goals and objectives set out in the accountability agreement.

Our board would also like to bring to your attention concerns we have regarding the sections of Bill 8 that will alter the relationship between the board and the CEO. Interference with this relationship, as contemplated by Bill 8, will jeopardize the success of our organization. It is our role and responsibility as representatives of our communities to establish performance agreements with our leaders. We will clearly articulate the expectations and responsibilities of this position, and it will be our duty to ensure that agreements are successfully implemented. Any ability of the government to come between this relationship will be detrimental to the hospital as a whole. We spoke on this issue at great length in February, and we urge you to closely examine the BC Auditor General's report to determine what worked and, most importantly, what did not work.

1610

Our presentation in February raised the issue of the conflict between Bill 8 and the Public Hospitals Act. We believe that hospitals still need clarification of health care acts that will govern our hospitals. Section 20 of the Public Hospitals Act very clearly states that we must provide service and treatment to those who arrive at our facilities seeking care. Our legal counsel has reviewed the amendments and has advised that accountability agreements between the board and the government, regardless of whether they directly or indirectly impact patient volumes, will translate into a restriction on the number of patients that can be treated at our hospitals. Furthermore, "these restrictions could place hospitals in direct conflict with their statutory obligations under section 20 of the Public Hospitals Act to treat every patient admitted under the order of a physician." When a person comes to a hospital for health care services, we do not, and we must not, turn them away. This legislation could restrict access to services and prevent us from meeting the essential and basic health care needs of the residents of our communities.

In conclusion, we are a strong community organization that is committed to the principles of the Canada Health Act and to our community. We have a strong

commitment to value-added quality improvement, a commitment that is vital to the success of our health care organization and the industry as a whole. Our board is motivated by pride and professionalism in what we and our health care providers do. We believe in accountability. We are accountable to the government. We are accountable to the community, and we are committed to meeting and exceeding our community's expectations. It is this determination and commitment that will continue to ensure we are successful in our quest to provide quality health care services.

You are faced with the difficult task of marrying several distinct views to create the right compromise for health care in Ontario. You need to strike the right balance. In your consideration of Bill 8, as you review the suggestions and recommendations that have come before you, we urge you to consider actions that will add value and accountability, not complexity and unilateralism, to our health care system.

The Chair: Thank you for your presentation. We have three minutes remaining—one quick question from each party. We'll start with Mrs Witmer.

Mrs Elizabeth Witmer (Kitchener-Waterloo): I notice here that one of the outstanding contentious issues continues to be the dispute resolution mechanism to deal with accountability agreements in the event that a resolution cannot be found. You say that we need to learn from the BC example. Did they have a dispute resolution mechanism?

Mr Madon: Yes, they had dispute resolution and they have made some recommendations. I cannot tell you offhand what those recommendations were.

Mrs Witmer: So they have found that at the end of the day there is a need to make sure the community does have input to that accountability agreement?

Mr Madon: That's correct.

The Chair: Mr Kormos.

Mr Peter Kormos (Niagara Centre): I appreciate your submissions, and I appreciate your patience with this government. This is the second round of committee hearings. You know that.

Mr Madon: That's right.

Mr Kormos: And we have yet to return to the House. Who knows? There may well be a third.

The Chair: Mr Leal.

Mr Jeff Leal (Peterborough): Thank you very much for coming back. I want you to comment on a real-life situation: Belleville, Ontario. The government provided resources to hire more nurses in Belleville. Instead of hiring more nurses to improve outcomes of the health care system in that area, the CEO took the money and topped up the compensation for the senior administrators there.

To me, that's why we need accountability agreements, because I served on a hospital board, and sometimes boards just become rubber stamps for what the CEO proposes. One of the things we want to achieve through these accountability agreements is to avoid the kinds of problems in Belleville, Ontario. I just want to get your comment on that.

Mr Madon: I don't believe there would be any concern on the example which you have just given. If the funds are earmarked for, let's say, the nurses in your example, than it is the duty of the board to ensure that the monies are only spent on that and nothing else.

The Chair: That brings us to the end of the presentation. Thank you very much for your presentation this afternoon. Have a good afternoon.

CATHOLIC HEALTH ASSOCIATION
OF TORONTO

SALVATION ARMY/TORONTO GRACE
HOSPITAL

The Chair: Next we have the Catholic Health Association of Ontario and the Salvation Army/Toronto Grace Hospital. I'd like to welcome you. Once again, 15 minutes for the presentation; any time remaining at the end of your presentation will be used for questions.

Mr Ron Marr: Thank you, Mr Chair and members of the committee, for welcoming us this afternoon and allowing us to share with you some of our continuing thoughts on Bill 8. My name is Ron Marr. I am the president of the Catholic Health Association of Ontario.

Joining me today are Major Dennis Brown, the president and CEO of the Salvation Army/Toronto Grace Hospital, and Peter Lauwers, a partner with the firm of Miller Thomson. Major Brown is here with me today to demonstrate to you the concern that is shared among all of the faith-based providers of health services in the province regarding Bill 8. Mr Lauwers is here today to help us answer any questions that you may have, particularly around the amendments and the background to the amendments that we are proposing to you.

Our comments to you this afternoon will be relatively brief, as we have already shared our concerns with you during our last appearance before the committee, on February 24. Before I comment on Bill 8, I will first summarize the contributions of the faith-based missions of health resource providers to Ontario's health care system. Then I will share with you our continuing concerns with this bill and suggest two amendments that will address our concerns and, in our opinion, improve Bill 8.

The Catholic Health Association of Ontario is an umbrella group that represents the Catholic health ministry in this province. The CHAO is a voluntary association of all Catholic hospitals, long-term-care, mental health facilities, and community health services in the province. There are 29 such institutions and services in the province, ranging in size from large teaching hospitals, long-term-care centres and psychiatric hospitals in our major health science centres to smaller facilities in smaller communities across the province. Also included in the membership of our association are the seven religious communities of sisters and lay groups that sponsor these facilities, and the Ontario Conference of Catholic Bishops, which is composed of all of the Catholic bishops in the province.

The Salvation Army has provided spiritual and health care to Ontarians since the late 1800s, and remains the largest non-profit, non-governmental provider of health and social services in the country. The Catholic and Salvation Army health ministries represent only two of the many faith-based health ministries in Ontario. There are many faith-based groups that provide a variety of formal and less formal health programs to Ontario residents and that reflect the pluralistic and diverse makeup of Ontario.

Our comments and recommendations to you today are shared and supported by the following faith-based groups or communities: The Catholic community through our 29 health care organizations on 39 sites; the Jewish community through Mount Sinai Hospital; the Salvation Army community through the Toronto Grace Hospital, which also operates in partnerships at Hotel Dieu-Grace Hospital in Windsor and the Scarborough Hospital; and the Anglican community through St John's Rehabilitation Hospital.

Faith-based health services strive to provide the highest-quality care with respect and compassion to all in need, regardless of religion, socio-economic status or culture. We collaborate in open partnership with other members of Ontario's health care system. We are dedicated to voluntary community governance to ensure accountability to the government and to the residents of the local communities in which we serve.

Faith-based facilities reflect a proven, community-based, voluntary approach to governance. Our boards of directors are representative of the cultural, linguistic, socio-economic and religious composition of the communities in which our organizations are located.

1620

Ontario is a truly pluralistic and tolerant province where a large variety of religious, cultural and linguistic traditions thrive and contribute significantly to the life, economy and health care system of this great province. It was often religious groups that responded to unmet community need by founding health care services from their own resources. These faith-based groups today sponsor approximately 20% of Ontario's hospitals, long-term-care facilities, mental health facilities and community-based services. We continue to respond to the ever-changing needs of the community from a mission-driven and faith-based perspective, adding a unique element to our health care system.

Over the last number of years, the leaders of all three political parties in Ontario have shown their support for this faith-based approach to health care by affirming their party's commitment to the maintenance of the mission and governance of the Catholic health facilities. Indeed, in an August 2003 letter to us, Premier McGuinty said:

"The Ontario Liberals recognize the invaluable contribution that the Catholic Health Association of Ontario ... and the caregivers you represent have made as partners in the delivery of quality health care in our province."

"As I have stated in the past, the Ontario Liberals are committed to preserving the Catholic health ministry in our province. We appreciate that governance issues are of

the utmost importance if Catholic hospitals, long-term-care facilities and home care providers are to preserve their ministry."

We support the need for accountability and express our desire to be accountable for public dollars. However, we continue to believe that the top-down, power-and-control approach of Bill 8 is not the best way to achieve accountability. We sincerely appreciate the amendments already made to Bill 8. However, despite these amendments, we are still concerned that the provisions and implementation of part III of this act could erode the mission of faith-based health resource providers in Ontario and jeopardize our ability to continue to contribute to the health of the communities we serve. The central problem with Bill 8 is that it continues to allow the government, through the Minister of Health and Long-Term Care or his or her designate, to impose anything it likes on health resource providers.

To mitigate these problems, we propose two amendments: the first to ensure that faith-based health resource providers continue to bring their unique contribution to Ontario's health care system, and the second to affirm the role of voluntary governance boards. We believe that our proposed amendments will achieve the government's objective of accountability while at the same time allowing the authentic continuance of faith-based health care in Ontario.

The Ontario Hospital Association has already expressed additional concerns of the hospital sector regarding Bill 8. The Catholic Health Association of Ontario has worked closely with the OHA, and we support their recommendations for amendments. We will not reiterate those this afternoon.

Let me be clear, before I share our amendments with you, that we are not asking to be excluded from the provisions of Bill 8 or from accountability. We believe in accountability and support the need for accountability. We are simply asking for some comfort that we will be able to continue to provide faith-based and mission-driven health care in this province.

We've taken the liberty of proposing specific language for your consideration in the two amendments we are submitting to you. I'll read those to you at this point.

Our first amendment is the inclusion of a clause in Bill 8 that we suggest be added as section 32.2:

"(1) Nothing in this part authorizes the minister or the Lieutenant Governor in Council to interfere, directly or indirectly, with the faith-based aspects of a health resource provider that has a faith-based mission or governance structure.

"(2) The powers under this part shall be exercised in the manner that is consistent with the faith-based aspects of a health resource provider that has a faith-based mission or governance structure."

The intent of this amendment is not unique to health care in Ontario. Yesterday, the Catholic Health Corp of Ontario shared with you the ways that other provinces have acknowledged the contribution of faith-based health care by entering into a variety of agreements that recognize and affirm the long-standing and valuable role of

faith-based providers within the health care systems of the other provinces.

This amendment we are proposing to you today also finds its precedent in the language found in section 257.52 of Ontario's Education Act, which governs the minister's authority when a school board is to be taken over by the minister for failure to comply with the Education Act.

We are asking for nothing more nor nothing less than that which has been provided to faith-based health resource providers in other provinces and to faith-based and French-language schools in Ontario.

I'll now turn quickly to our second amendment. The intent of our second proposed amendment is the same as that proposed by the Ontario Hospital Association. It relates to a dispute resolution clause should negotiations for an accountability agreement between the minister and a health resource provider fail after the 60-day negotiation period. We believe that an agreement can only be successful if both parties enter into an agreement willingly and without compulsion. Our proposed second amendment, or a variation of it, is intended to facilitate the achievement of accountability agreements that are entered into willingly and without compulsion by the minister and the health resource provider.

Our second proposed recommended amendment reads as follows. Here we suggest the inclusion of a clause to be added in section 21.1 and section 26.1 as subsections (4.1) and (4.2).

"(4.1) Either the Minister of Health or the health resource provider may request the assistance of a facilitator to be mutually agreed upon and jointly appointed by them to assist in resolving the matters in dispute. If the minister and the health resource provider are unable to agree on a facilitator, then the Chief Justice of Ontario shall make the appointment."

"(4.2) The facilitator shall confer with the parties and endeavour to effect an agreement within five days of the appointment. The parties shall co-operate with the facilitator."

Faith-based and mission-driven health care providers wholeheartedly support the overall theme and intention of Bill 8—the preservation of a universal public health care system in Ontario. We are all committed to the five principles of the Canada Health Act: public administration, comprehensiveness, universality, portability, and accessibility. Also, and most importantly, the fundamental values of accountability and improvements to the system are important elements of the philosophy of faith-based health care.

We ask you, the members of the standing committee on justice and social policy, to give serious consideration to our recommendations and comments. We thank you for the opportunity to meet with you today and we would now be pleased to answer any questions you may have.

The Chair: Thank you very much. We are down to about three minutes. A quick question from each party.

Mr Kormos: I appreciate what you have to say, because of course down where I come from in Niagara region we have Hotel-Dieu Hospital in St Catharines.

My concern is there's been a hostility toward faith-based hospitals over the course of a number of years now. Governments seem to be trying to do through the back door what they wouldn't dare politically do through the front door in terms of shutting these places down. I find your proposition regarding the amendments restricting or, rather, exempting control by the minister—exempting the faith-based aspects from any control or interference by the minister, especially when they're so consistent with the sections in the Education Act that you provided us with—so I suppose, Chair, I would put as a question, how are these amendments in any way offensive or inconsistent with the goal of the government in terms of this legislation? The amendments make eminent good sense.

The Chair: We are at the end of one minute.

Mr Kormos: I've made my point.

The Chair: Next, Ms Wynne?

Ms Kathleen O. Wynne (Don Valley West): Thank you for coming today. I guess I'm just trying to work out—because we've heard this argument a couple of times and I know there's been a discussion in the ministry about this. My understanding is that there's nothing in the bill that would undermine the faith-based aspects of your delivery. I'm puzzled—the reverse of what Mr Kormos was saying—about why this is necessary. If there's nothing in the bill that is threatening, then why would this be necessary? What's the fear that you're trying to allay?

Mr Peter Lauwers: The accountability agreement is very broad in what it covers. We foresee a possibility of being directed by the minister to provide services that are inconsistent with our moral mission; for example, abortion, sterilization, euthanasia in the future, those sorts of things. We're concerned about shutting down programs on a cost basis, such as chaplaincy. We're concerned about being forced to share CEOs or senior officers.

1630

Mrs Witmer: Great presentation; excellent amendments. Maybe you can continue and use my time to tell me why you feel this is necessary.

Mr Lauwers: I don't know if I can add much more to it, but the notion of shared CEOs and shared senior officers is a problem for us because it would interfere with the faith-based mission of the system as the compromises begin to run through. These are all possibilities under the legislation. It doesn't expressly say so but it doesn't say not, either. So we don't believe that the protections we're talking about will interfere with the economic and systemic concerns of the government, but they will provide faith-based organizations with a measure of comfort to know that that part of their program is safe.

Mrs Witmer: I guess you've mentioned here that this type of commitment has been made in other provinces, and also in the educational system, so you're not asking for anything more and nothing less.

The Chair: Thank you very much for your presentation this afternoon. Have a good afternoon.

**ONTARIO FEDERATION
OF COMMUNITY MENTAL HEALTH
AND ADDICTION PROGRAMS
ST JUDE COMMUNITY HOMES**

The Chair: Next we have the Ontario Federation of Community Mental Health and Addiction Programs. Welcome. Make yourselves comfortable. Once again, a presentation of 15 minutes; if you don't require all the time for your presentation, we'll split it between the parties.

Mr David Kelly: Thank you. First, on behalf of the Ontario Federation of Community Mental Health and Addiction Programs and St Jude Community Homes, we want to take this opportunity to thank you for allowing us to come and make this presentation. I also want to thank each and every one of you for the support you've given over many years to addiction and mental health services in your communities. Believe me, we need that support.

This legislation speaks to issues that are very important for people with mental illness, for the volunteers who lead the organizations that provide services and for the public. The Ontario Federation of Community Mental Health and Addiction Programs envisions a community mental health and addiction system which is accessible, flexible, comprehensive, responsive to the needs of individuals, families and communities, shaped by many partnerships, respectful of human dignity and rights and accountable to those it serves. The federation brings over 200 community mental health and addiction programs and services together in the province of Ontario, all the way from Red Lake to Windsor, to help provide effective and accountable, high-quality services.

I'd like to turn it over to Angela for a second.

Ms Angela Shaw: So we're going from the big—200—to a little non-profit supportive housing program here in Toronto that is governed by a voluntary board of directors. Its mandate is to provide high-quality housing and support service for people who have serious and persistent mental health problems, and to support these people as they journey through to recovery. There has been a lot written about recovery but, simply put, it's learning how to deal with some of the stigma, the isolation, the low self-esteem and the poverty and get on with your life.

St Jude Community Homes opened in 1991. We serve 36 citizens and we hope to serve 30 more next year under the homelessness initiative. Today we're here specifically to talk about part III of the bill, which is the accountability piece, but we will interject little bits about the Ontario Health Quality Council and the commitment to medicare, and a little bit about insured health services. So you have before you 30 pages, but we're not going to read it; let me reassure you of that. We're just going to highlight bits and pieces that are our passion.

Mr Kelly: As Angela explained, in our presentation I just want to talk about Bill 8, which is receiving second reading and has been referred to committee here today. This bill would require health resource providers, in-

cluding hospitals, to enter into an accountability agreement with the Minister of Health and Long-Term Care. This agreement would permit the minister to issue compliance directives and impose sanctions in the event of non-compliance. Until the bill is passed, health care institutions are under no specific legislated obligation to account for the billions of dollars of public money they spend.

For community mental health and addiction programs, those accountability mechanisms are already in place. In addition, the current agreements seem to hold community mental health and addiction programs to much higher standards than are proposed in Bill 8. In fact, when you look at the accountability structures faced by community organizations, not only will they have the accountability with the Ministry of Health, but they will with every funder or ministry they deal with. So you can be looking as a community organization and face five or six accountability agendas, from the federal government to the United Way to other funding organizations.

Ms Shaw: Around 1998, the government directed the ministry to establish these written agreements. They were consistent with mental health reform and the work that the mental health accountability reference framework group was doing, as well as the document *The Road Ahead*, which sort of deals with the addictions section.

What was envisioned and what is now in place is a common transfer payment agreement for all community mental health and addiction programs. The Ministry of Health and Long-Term Care initiated this in 1998 and passed it on through all of the organizations, I believe, in September 2002. The whole point at the beginning was to raise awareness about accountability issues and to encourage continuous quality improvement with the transfer payment agencies and have them start to reference best practices. At that time, the government of the day stated:

“The experience of government overall is that clear expectations, terms and conditions of funding, performance monitoring and reporting requirements documented in an agreement between the Ministry of Health and Long-Term Care and funded agencies is the most appropriate way to provide certainty and protection for both sides.”

As a taxpayer—and I know I’m editorializing—I don’t know why people are having a problem with accountability. We’ve got these transfer payment funding agreements. They’re consistent across the board. There’s ease of administration, certainly with the ministry. They’re not perfect. They could be improved upon. But the net result of not signing these for community mental health and addiction programs was that you wouldn’t get funding. It would be gone. That was it.

So the TPA that each person, each agency, signs ensures that the funds are only used for the purposes set out in the annual operating plan, and you can’t make changes to that plan without ministry permission. It also grants the ministry powers, among others, to impose additional terms and conditions on the use of funds as it

considers appropriate, to inspect and copy financial and non-financial records on 24 hours’ notice or to do a partial or full audit, and to terminate the agreement immediately under certain specified situations.

We’re using tools to do outcome measurements and we’re demonstrating that we’re providing cost-effective services and we’re accountable. I think, most importantly, we feel that, because we’ve got these statistics now, as pale as they might be compared to what hospitals collect, we are providing a good service and we’re being accountable, not only to government but to the clients we serve and to the citizens of Ontario. We feel very strongly that taking care of the public interest states clearly the collective roles and responsibilities, that there is a transparency here, that there’s an encouragement toward continuous quality improvement, that there’s value for the monies received and how they’re spent, because we know resources are very scarce, and there’s a process for reporting. The consistency and trust are there, and there truly is a focus on outcomes.

My question is, we’re so heavily accountable down in the community, so why should other health resource providers be handled differently? We believe that to truly transform the health care system, all parts of it must have similar accountability structures so we can compare outcomes on a level playing field. Privacy is one really good piece that’s being worked on there, where we can all communicate back and forth and we know that the rules are all consistent. This accountability is another piece to really make it look like a system.

1640

Mr Kelly: We agree that all transfer payment agencies must be accountable, not only to the government but to the clients who use the services—the public—and we support the government’s initiative to identify opportunities for greater and more consistent accountability.

As Angela just pointed out, though, the federation views Bill 8 as a key building block for transformation of the health care system. The privacy legislation will make all providers of health care in the province of Ontario use the same mechanisms when transferring client information. Bill 8 will set up an accountability agenda that will allow us to compare different services in the province, define roles and start looking at the outcomes of each and every service, so we can do cost comparisons on different case management models, like those that may be based in the hospital or those that may be based in the community sector. It makes a level playing field. If we are to transform and address some of the problems within our health care system, we need to have that for all of the providers within the system.

We get to our recommendations part. I’m just going to quickly start highlighting them for you, so if you have any questions, we’ll have time for those.

Recommendation 1: In developing new accountability arrangements and reviewing current ones signed by community mental health and addiction programs, the government should be guided by the principles of

consultation, collaboration, transparency and acting in the public interest.

An effective accountability mechanism must provide information that can be used to improve the quality of services, minimize the time that staff providing direct service must spend entering data instead of working with clients, and have sufficient funding available to enable effective implementation.

Recommendation 2: That any accountability mechanism must take into account the principles stated above, and include adequate funding for implementation, so as not to divert resources from clients.

This is a great problem faced by the community mental health and addiction field, as we have accountability agendas that have come down on to our organizations with no resources, so what we continue to see is a shrinking of the availability of services. If there are not going to be resources, they're not going to be successful. I know you hear this continuously, but it really is a basic truth in this whole process.

Recommendation 3: The Minister of Health and Long-Term Care may require a CEO or board to enter into an accountability agreement only when there is an extraordinary breach of their legal responsibilities.

Recommendation 4: The government has a responsibility to provide chiefs, CEOs and/or boards the support they need to carry out their obligations.

Recommendation 5: The legislation must be clear as to the purpose for the intervention and what is the intended goal of that intervention.

Recommendation 6: We'd like to comment on the Ontario Health Quality Council, that factors to be considered in selecting members of the council should be amended to read:

"(2) In appointing the members of the council, regard shall be given to the desirability of appointing,

"(a) experts in the health system in the areas of patient and consumer and family issues and health service provision, including mental illness and addictions and mental health services;

"(b) experts in the areas of governance, accountability and public finance;

"(c) persons from the community with a demonstrated interest or experience in health service."

Recommendation 7: That subsection 5(5) be amended to remove the exception to tabling the business plan and require the plan to be made public once it is approved by the minister.

Recommendation 8: That the council be authorized to recommend to the Minister of Health and Long-Term Care, or to any other appropriate governmental body, the collection of statistical information necessary to carry out its mandate.

Angela, do you want to comment?

Ms Shaw: The commitment to medicare and the Canada Health Act: I've been a nurse for 32 years. My nursing association holds true to the Canada Health Act. I hold true to the Canada Health Act. I can remember writing a thesis in the 1980s commenting on the declar-

ation of Alma Alta that was promoting health for all by the year 2000, and here we are in 2004 and the Canada Health Act is really too narrow to reflect the changes since 1967. There is so much that is being done in the community that is not an assured service that is more cost-effective, and sections there do really need to be opened up a little bit to cover those kinds of things.

Interjection.

Ms Shaw: We have two minutes? OK, then we'll stop.

Mr Kelly: The rest of our recommendations are in—

The Chair: Go on with your recommendations. I just wanted to alert you that you have two minutes. If you want to talk about the other recommendations, feel free.

Mr Kelly: We'd also, at this point, like to acknowledge the Centre for Addiction and Mental Health and the Canadian Mental Health Association, because what we have here is a field of addiction and mental health providers in Ontario saying, "Move ahead on Bill 8 and let's level the playing field so we can all participate fully as providers in the health care system."

Ms Shaw: What you have in front of you is our position paper. There are 13 recommendations. You guys all read, I know.

The Chair: We do have one minute remaining. Perhaps the government side has a question.

Ms Monique M. Smith (Nipissing): We really appreciated your presentation, and you've given us a lot to think about. I just had a question. When you were talking about the funding agreements that you're presently obliged to participate in, you said, "They're not perfect. They could be improved upon." In 30 seconds or less, what would be some of the things you'd like to see improved on?

Ms Shaw: One size does not fit all, and there was no collaboration; these were sort of sent down. They're not perfect, but they are a start. I did bring a copy—not a signed one—if you wanted to circulate it and just take a look at it.

Mr Kelly: One example is that community programs can lose their funding in 60 days; with hospital programs, it's 90 to 120 days. Again, I don't know why different parts of the health care system are treated differently.

The Chair: Thank you very much for your presentation. That brings us to the end of the 15 minutes. Have a good afternoon.

ONTARIO DENTAL HYGIENISTS' ASSOCIATION

The Chair: Next we have the Ontario Dental Hygienists' Association. Welcome and make yourself comfortable. There is water there. Once again, 15 minutes, and should we have time remaining at the end, we will divide it between the parties.

Ms Margaret Carter: Good afternoon. My name is Margaret Carter and I'm the executive director of the Ontario Dental Hygienists' Association, also called the ODHA. It is a pleasure for the ODHA to speak with you

again regarding Bill 8, the Commitment to the Future of Medicare Act, 2004.

As you know, the ODHA made a presentation on this bill earlier this year, when it was before this committee prior to it receiving second reading. We are pleased to be back to offer some of our recommendations that we believe will help further improve Bill 8.

The ODHA realizes the importance of this legislation to the future of health care delivery in the province of Ontario, and for this reason it makes it all the more necessary to conduct public hearings, to hear first-hand the advice and recommendations of not only the health care providers, but also the recipients of health care: the people of Ontario.

We congratulate the government, and the Minister of Health in particular, on what is, I believe, the unprecedented move to conduct public hearings after both first and second readings of Bill 8. With the changes that have already occurred after the first round of hearings, and with the amendments that will, I hope, be made after the second round, we can anticipate a bill that will indeed be a commitment to the future of medicare. It is incumbent on all of us—health care stakeholders, the government and the public at large—to work together to make sure that this bill achieves its stated objectives.

The ODHA represents approximately 6,000 dental hygienists across the province, accounting for about 85% of the total number of dental hygienists registered to practise in the province today. This makes us one of the largest health care professional associations in Ontario.

One of the primary objectives of Bill 8 is to ensure that all Ontarians have access to quality, affordable health care that is based on need and not on the ability to pay. It also strives to enhance accountability in the system for the benefit of the people of Ontario. The ODHA agrees with and supports these objectives.

As you may be aware, one of the issues facing dental hygienists today is the restriction on delivery of a very necessary health care service to the people of Ontario, particularly those in long-term-care facilities, as well as those in rural and remote areas and individuals who may not be able to afford access to a dentist. Many of these individuals are in fact some of our province's most vulnerable.

Without going into any great detail, the issue of which I speak concerns the requirement of dental hygienists to obtain an order from a dentist prior to performing our authorized acts. With the amendment to the Dental Hygiene Act that we are proposing, dental hygienists will be able to provide their services to all Ontarians, including those who are not necessarily able to travel to a dentist's office, whether because they are bedridden in a long-term-care facility or because they do not have the financial resources to see a dentist.

Studies have shown that good oral hygiene can reduce the incidence of pneumonia; that seven out of nine diabetics who improve their oral health reduce their need for insulin; and that some heart surgeries are delayed or cancelled altogether because the patient is in need of

teeth scaling to reduce the risk of post-operative infection. If dental hygienists are permitted to fulfill their potential as prevention specialists, this will reduce the overall cost to the health care system through the prevention of oral disease and promotion of oral health and, therefore, overall health.

1650

This amendment will ensure that Ontario's health care system truly meets the objectives of Bill 8, in that it is a system that is truly affordable and accessible.

We have been working with the government and MPPs of all political stripes to help resolve this issue, and we appreciate the support of so many of you. To be quite frank, I look forward to the day, which I hope is very soon, when I no longer have to talk about this issue again and instead I can tell you how many individuals across the province are now receiving necessary dental hygiene services as a result of this simple amendment, when previously they were not.

In February of this year, when the ODHA first presented to this committee, we outlined a number of concerns and issues we had concerning Bill 8. We are pleased to see that, as a result of a number of amendments this committee and the minister have made, many of our concerns have been significantly reduced.

We stated in our previous deputation that the ODHA welcomes the provisions made in Bill 8 with respect to the establishment of the Ontario Health Quality Council. We are pleased that further changes have been made to this section of the bill that will ensure a more effective and productive council.

The ODHA is also pleased that amendments have been made with respect to the protection of personal health information specifically as outlined in section 13 of Bill 8. Our concern prior to the amendments was that this section of the bill would allow for another stream of access to, and disclosure of, health information. We were concerned that Bill 8 would prevail over Bill 31, the Health Information Protection Act, 2004. We are pleased that Bill 8 has been amended to provide a single regime for the protection of personal health information falling under the jurisdiction of Bill 31 on the condition that it is proclaimed.

Our concerns prior to the amendments made to Bill 8 were predominantly with respect to part III of the bill, which dealt with the issue of accountability.

The ODHA supports and encourages an accountable health care system. We appreciate the amendments that have been made to this part of the bill. In particular, we applaud the inclusion of the reference to "public interest" in subsection 20(2).

However, the ODHA is still of the belief that part III is far too draconian and heavy-handed, placing far too much power in the hands of one individual, namely the minister. While much of the wording may have changed with respect to part III of the bill, the heavy-handed unilateralism prevails.

For example, while the amendments allow for the minister and health resource provider to negotiate terms

of an accountability agreement, they will have just 60 days to do so, as set out in subsection 21(2). If, after 60 days, an accountability agreement has not been entered into, the minister will "direct" the health resource provider to enter into an accountability agreement set by the minister, and the health service provider will be forced to comply. In effect, this provision does little to address our concern and simply delays the unilateral imposition by the minister by 60 days. The minister would still have the power to impose a wide range of penalties on health resource providers for not complying with his or her directives, and these penalties can be quite onerous.

Many of the boards that govern the various health facilities, such as hospitals, long-term-care facilities and other facilities that would fall under the definition of health resource provider, are comprised of hard-working volunteers and dedicated members of our communities. Under the Public Hospitals Act and under corporate law, these boards are given the responsibility to make decisions respecting the institutions' administration and management. Imposing agreements on these facilities usurps the fundamental role of the board and effectively nullifies any authority that it has. As a result, forcing the imposition of an agreement silences the voice of the community.

We proposed to you in our previous submission that, without substantial revisions to part III, the ramifications of the bill's implementation would include an unworkable and even hostile relationship between the government and health service providers. The ODHA's beliefs remain the same today. Despite the major rewording of this part of the bill, it still grants far too much power to one individual and diminishes the authority of our valuable and community-based boards.

The Ontario Hospital Association has put forward an alternative to enforcing accountability agreements. The OHA proposes that, rather than enforcing an accountability agreement after 60 days of unsuccessful attempts at negotiating one between the minister and the health resource provider, an independent third party should step in and act as a mediator between the two parties.

The ODHA supports this recommendation. A mediator would ensure that both the government and the facility work together. A mediator will review the situation and will make recommendations on how best to achieve an agreement.

An approach such as this will not grant extraordinary powers to the minister, nor will it require the imposition of onerous penalties on board members or CEOs. Instead, an agreeable solution will be sought and an accountability agreement will be developed through co-operation and dialogue, to all parties' satisfaction. It will also help stifle any hostility created in the health care system as a result of the implementation of this legislation as it currently is written.

I began my presentation today talking about an issue that dental hygienists are currently facing with respect to access to necessary health care services, and I would like to end on the issue of accessibility.

Bill 8 is supposed to be about improving accessibility in the health care system. It was to reduce the wait times for such things as MRIs and CT scanners, and it was also to prohibit queue-jumping for important health care services. Bill 8 was introduced to protect the universality of our health care system, something Ontarians consider of vital importance.

Unfortunately, Bill 8 fails to meet these objectives. In fact, Bill 8 makes no mention of prohibiting private hospitals, private MRI and CT scan clinics. The bill also makes no mention of how wait times will be reduced.

If the intent of Bill 8 is still to improve the accessibility of our health care system, then these issues need to be incorporated directly into the legislation.

In closing, I would like to thank you for the opportunity for ODHA to speak before you again with respect to Bill 8. It is quite evident, given the increased opportunity for public consultation, that this government is serious about ensuring that Bill 8 is drafted so that it will accomplish what it was intended to do. We appreciate the dialogue and the debate, and we look forward to seeing a much-improved bill as a result.

I would be pleased to take any questions or comments you may have.

The Chair: Thank you for your presentation. We do have four minutes remaining. We'll start with the official opposition, Mr Hudak.

Mr Tim Hudak (Erie-Lincoln): Thank you, Ms Carter, for your presentation. It's good to see you again.

I think you've summed this up very nicely at the end, because the bill is not about accountability or access; the bill is really about central control. It puts tremendous power in the hands of the Minister of Health or, in reality, because we're talking about probably hundreds or even thousands of these agreements, tremendous power within the bureaucracy in the Ministry of Health. Having dealt with them on many occasions, I'm not confident they can get through these agreements in any kind of timely fashion or efficient fashion. The minister will be faced with hiring a whole lot more people to bring these agreements forward or he'll be faced with tremendous delays as a health care provider for this legislation. I think you hit the nail on the head in that respect.

The second question I had for you dealt with the amendments to the act and the Dental Hygiene Act that you're proposing, that you've been championing. Did you have any commitments from the Premier or the government before the campaign that they supported those changes?

Ms Carter: We had a commitment from the Premier that he supported the recommendations, yes.

Mr Kormos: Ms Carter, thank you kindly. I appreciated the opportunity to talk with you folks a few weeks ago here at Queen's Park.

As we get closer and closer to May 18, I'm starting to understand how important this bill is to the government, how incredibly critical this bill is, especially part III, to this government once their budget is announced because I believe we are looking at some major slashing and

cutting of health care services—chiropractic, physiotherapists, optometrists—and that this is the tool, reminiscent of governments past—the toolbox and the tools—whereby Queen's Park, the government, can suppress grassroots rebellion against their delisting of huge elements of health care. Just watch. I hope I'm wrong. I've been around long enough, I can connect the dots pretty good. I can even colour inside the lines. Just watch. May 18 is going to be all-telling. Thank you kindly.

Mr Ted McMeekin (Ancaster-Dundas-Flamborough-Aldershot): I'm very excited by what you said—a different perspective. I believe that our government has more tools in the toolbox than hammers and screwdrivers. In fact, we're very much committed to wanting to see a multidisciplinary approach.

I come at this with a particular concern about seniors. The requirements under the Long-Term Care Act or the Nursing Act or whatever the heck act it is—I know it's 35(3)(b) or whatever—that every senior needs a complete oral exam upon entering into a long-term-care facility is only happening about 44% of the time.

I think there's an incredible role here to play and I hope and pray that Bill 8 or some learning that we've had here can help us to move into that so that we could free that up and really use the skills that you have. I say that by way of affirmation. I would invite you to make any comment on that.

Ms Carter: Certainly we would like to see a change to the Dental Hygiene Act that would enable our members to realize their full potential for the health care system, absolutely.

Mr McMeekin: It needs some fine tuning.

The Chair: Thank you very much. That brings us to the end of our 15 minutes. Thank you for your presentation and have a good evening.

1700

OTTAWA HOSPITAL

The Chair: Next we have the Ottawa Hospital. We welcome you.

Dr Jack Kitts: Thank you very much. I'm Dr Jack Kitts. I'm the president and CEO of the Ottawa Hospital. To my left is Ms Peggy Taillon-Wasmund, who is the director of our executive services and chief privacy officer.

In the next 10 minutes or so I'd like to walk you through a brief history of the Ottawa Hospital and then talk more specifically about opportunities to partner in Bill 8.

In your package, which I believe has been circulated to you, there is a slide deck that provides a summary of the presentation. There's a delegation-of-authority policy that was passed by our board of governors that I think will be helpful as we move forward in performance agreements, and then a brief synopsis of what we believe are the attributes of a high-performing hospital.

The Ottawa Hospital is the product of a merger April 1, 1998, where two large teaching hospitals in Ottawa and two smaller community hospitals merged to form the Ottawa Hospital. In addition, a transfer from the Royal Ottawa psychiatric emergency services was achieved in 1999, and the heart institute and the rehab centre also form part of the Ottawa Hospital. In all, it's a very large, complex, tertiary care, academic health science centre with more than 10,000 employees, 1,200 physicians and more than 100,000 weighted cases.

The map there of eastern Ontario shows where Ottawa is situated, and I draw your attention to that not because I don't think you know where Ottawa is but to show how we provide a regional service right along the Ottawa River, from Deep River in the northwest all the way to Cornwall in the east. So we're a large regional resource.

Our mission: Like any other academic health science centre, we have a tripartite mission where we provide patient care—particularly tertiary complex care—educate future health professionals and provide innovative research. In addition, because of our situation in the region, we must provide regional care all the way from Deep River to Cornwall, and that becomes important as I speak later on about performance agreements. In addition, being in Ottawa, we function in a bilingual environment.

Our challenge, like other academic health science centres, is, how do we in eastern Ontario respond to community health needs, how do we develop as a centre of academic excellence, and how do we distribute a limited amount of resources across a wide range of programs?

First, let me be very clear that we are 100% behind the intention of accountability in the health system. The Ottawa Hospital has for the past few years supported and promoted initiatives to establish meaningful accountability in the Ontario health system. We believe that shared accountability will optimize Bill 8, and I'll elaborate on that further. Accountability mechanisms, however, must be practical and appropriate.

A fundamental problem with the system is that there is much inequity as to how hospitals are dealt with and funded. There is no clear funding formula, no clear measures on performance, and no transparency in the system. We believe that the system has been politicized to a great extent in the past. We believe that accountability, or the introduction of accountability, will help deal with all of these challenges.

Accountability, however, necessitates that we have clearly defined measures, agreed-upon targets or goals, and then the partners have the authority to be able to act in achieving those targets. Those are prerequisites to have an accountability agreement.

We believe that we should keep it simple. The framework should be quite simple. One such framework is outlined in the slide "Keeping it Simple..." whereby we look, somewhat like a balanced score card, at initiatives to improve integration, to improve quality of services on a regional basis, to improve access to services in co-ordination of care and, finally, to improve financial performance and sustainability.

Once this accountability framework is agreed upon, we must create alignment in the system. The performance agreements would serve to do just that. Alignment would be between the Ministry of Health and the board of the hospitals. The board then delegates the authority in the performance agreement to the CEO. The CEO then implements or executes the performance agreement, and the board monitors it back through the Ministry of Health.

In the past year and a half at the Ottawa Hospital, we have passed a delegation-of-authority policy whereby the board delegates the authority for the operations and direction of the hospital to the CEO. What that policy necessitates is that the CEO develops, with his senior team, a quality plan, a human resource plan, a maintenance and renewal plan and then an operating plan that supports that. These plans are brought forward to the board, the board approves the plans, and the CEO then executes the plans and brings back monitoring on a quarterly basis. This ensures that the board, the CEO, the management team, right down to the front-line staff, are all aligned in what the goals and objectives of the hospital are. We would argue that this sort of mechanism could be brought up to the ministry to ensure that alignment is with the ministry, the board and the CEO.

One other point we'd like to make is, being out in eastern Ontario, the Ottawa Hospital in the last couple of years has led a number of integration initiatives whereby we work collaboratively with our health partners in the large region. We're concerned that signing performance agreements with individual hospitals may negatively impact on the relationships and collaboration between the various health partners, in terms of working as a system. So we believe that looking at integration through Bill 8, and signing performance agreements that would look at the system and the region, as opposed to individual institutions, would be something that would be very important if we're going to truly create a better system.

We believe that there are also many best practices in the delivery of health care accountability and integration across the province. We would encourage building on those best practices across the province.

Working together: The Ottawa Hospital believes that improving accountability and enhancing performance within the hospital sector can be achieved through a partnership. It has to be truly a partnership between the government and the Ontario hospitals and I would argue for extending it further into the system.

In terms of the future, we believe, like most of you, that health care is not sustainable without significant change. We have adopted a culture at the Ottawa Hospital, including accountability, sustainability and leadership, in bringing about much needed change to try and improve the system. That's why we embrace this direction in terms of accountability.

In summary, then, accountability in the health system is absolutely essential and we certainly support that direction. Performance agreements that are mutually agreed upon will make a better health system by ensuring

that we have alignment at all levels of the partnership. I think we must consider looking at the health system in regions, as opposed to individual organizations, if we're truly going to improve the system. I believe that implementation will be the key to success. Accountability and performance agreements, properly executed, will align the goals and objectives of the Ministry of Health, the boards of the hospitals and the CEO and their management teams. In turn, clear performance measures and targets will lead to improved health for the residents of Ontario.

The Chair: Thank you for your presentation. We have eight minutes remaining, so we'll split it. We'll begin with the third party.

Mr Kormos: Thank you kindly. A whole lot of participants in the hearings talked about dispute resolution mechanisms, to avoid the imposition of the agreement after what many perceive as such a relatively short time frame. What have you got to say about that?

Dr Kitts: If we keep the agreements simple, as I suggested in one of those slides, and agree upon a framework that allows us to do that. I believe that, as we suggested in here, a delegation-of-authority policy, if you will, which we've included, would include that the ministry says to the boards, "We want you to develop a quality plan, a human resource plan, a capital renewal and development plan, and then create the operating plan that supports that." Bring it forward. If we approve the plan, then we're all aligned in proper execution and the CEO executes it. If we can't agree on that, then I would agree that we do need some sort of alternate dispute resolution to bring about an agreement, because I think a unilateral agreement is not a good agreement.

1710

Mr Kormos: It's not an agreement. It's oxymoronic.

Dr Kitts: Exactly.

Mr Kormos: That's number one. I hear what you're saying, but I hear other folks—you were in the room, I suspect, when somebody illustrated the problem by saying, "Well, hospitals get money for nurses and then they spend it on CEOs." Right? My response is, "Lay charges." It sounds like fraud to me. People should be going to jail. I mean, Conrad Black's got his problems. Guité's got his problems. It sounds like, if that's the case, there are a few CEOs in hospitals who should have theirs. What do you say about that?

Dr Kitts: I would hope that this sort of agreement would take us up a level from how the money is spent, and agree that if you meet the quality targets, the human resource targets, the efficiency targets and the operating targets, I don't think it's important as to how much was spent on what.

Mr Kormos: Yes, there's that disjoint there between what you're saying and what other folks are saying. Thank you kindly.

Dr Kitts: I'd keep it at the higher level.

Ms Peggy Taillon-Wasmund: Just to add to that point, our board chair has made it very clear that if our CEO is not performing under this delegation of author-

ity—and our board has a very rigorous performance management review of our CEO's performance on a quarterly basis—our board chair isn't going to cut his salary. He'll fire him. So it's very clear that if you are aligned with true performance management, there are repercussions for that sort of activity.

The Chair: We move to the government side.

Ms Smith: We really appreciate your presentation, Dr Kitts and Ms Taillon. Thank you for being here today. I had just a couple of comments and questions. I really liked your ideas around adopting an approach to review and promote best practices, having just finished an extensive review of long-term care and supporting the promotion of best practices and sharing best practices. I think that's a great idea, especially on a regional basis. So I commend you for that.

I wanted to just go into a little more detail on your ideas around signing regional performance agreements. In your model, from what I understand, you're trying to create a broader scope for these accountability agreements, but I just wonder who would then be signing the accountability agreement. Who would be accountable on the side of the service provider in your model?

Dr Kitts: That's an excellent question, because somebody has to be held accountable. Right now, I hold a regional CEO forum for hospital CEOs, and as I alluded to in my statement, I think I need to expand that to include the broader system. But right now, we have 16 hospital CEOs come together on a quarterly basis to create a work plan. One is a regional electronic health record, a physician human resource plan that we then create and execute, and we all provide in-kind services and pay for what is necessary.

Right now, I think we would all have to sign off on it, the way the system is developed. But certainly in our region, we have that kind of collaboration.

Ms Smith: Can you sit back a little bit? We're losing you.

Dr Kitts: Yes. In our region, we have that sort of collaboration now, and I would think that if the Ottawa Hospital signed a performance agreement that said so much service provided, and Pembroke couldn't provide the service because they lost their orthopaedic surgeon, it would not be a collaborative model; whereas if it was a regional service, it doesn't really matter which organization does it, as long as we provide the care in a quality way.

Ms Smith: Just to tweak that a little, would it reach the same end if we looked at accountability agreements on a regional basis? They would still be entered into with each facility, but you'd look at it in a broader scope to make sure that you're allowing for that flexibility and that give-and-take within your various institutions.

Dr Kitts: I think considering the system now, that would probably be the ideal way to go, yes.

Ms Smith: That would work. OK. Thank you.

Mrs Witmer: Thank you very much for an excellent presentation. You've spent a lot of time here talking about some of the steps that need to be taken before you can actually move forward with the accountability agree-

ments, one of them being you've got to define what accountability is and how you're going to measure that. I guess I would ask you—obviously, the government is going to move forward, and everyone who's come here has agreed with the need for accountability—what would be the preliminary steps that you would see the government taking, because another key issue that you've identified is the fact that there's not equity of funding? What does a government need to do before they'd even be able to go ahead and do that?

Dr Kitts: That's an excellent question. I think we're doomed to fail if we do enter into performance agreements where neither side can actually deliver and it's not clear what we're trying to achieve. In health, as you know, performance measures and targets are something we talk about but don't actually have.

I know the ministry is currently working with the OHA to look at a fair funding formula. I think a volume- and rate-based funding formula would help equalize the system. We need to look at what investment is needed at one time in terms of facilities and equipment, because not all the hospitals are starting from a level playing field. I think we need to look at information technology, IT, in hospitals to see what is required by each individual hospital to bring it up to speed, and then start entering into accountability agreements from a more level playing field.

The Chair: Thank you for your presentation. We wish you a good evening.

GTA/905 HEALTHCARE ALLIANCE

The Chair: Next we have the GTA/905 Healthcare Alliance. Welcome. Make yourself comfortable. There is water, should you require it. You have 15 minutes for the presentation. Should you not require the total time, we'll split it between the parties.

Mr Kirk Corkery: Thank you, Mr Chair. Good afternoon. My name is Kirk Corkery. I am the incoming chair of the GTA/905 Healthcare Alliance.

Before getting into the substance of our presentation, I would like to tell you a little bit about our organization. The 905 alliance is the collective voice of the 11 hospital corporations operating 22 hospital sites across the GTA/905 region, from Oshawa to Burlington and north to Newmarket.

For over eight years, the alliance has represented some of the largest community hospitals in Ontario. Together, our members offer care to over 2.5 million Ontarians, approximately 20% of Ontario's population. Each year, alliance member hospitals work closely with the Ministry of Health to respond to the many and increasing health care needs in our communities—communities that grow by 60,000 new residents each year, almost double the growth rate of the province. That's equivalent to having the population of Kingston added each year.

In terms of Bill 8, we would like to commend the government, first, for providing another opportunity for public input and, second, for already proposing amend-

ments to this legislation after listening to the many recommendations made during the first round of hearings.

We hope the government will continue to listen and give due and full consideration to the recommendations being made during this second round of hearings. The advice and recommendations we are offering are provided in a spirit of our historical partnership and collaboration with the government, and are based on our shared goal of ensuring that Ontarians continue to have access to high-quality health care when and where they need it, which means as close to home as possible.

As organizations operating under a structure of voluntary governance, alliance hospitals have a long history of being accountable to government, accountable to our patients and their families, and also accountable to the many health care providers and other staff working in our hospitals who provide treatment and care for patients.

Alliance hospitals have been accountable when the government's goal was to bring services closer to home. Our member hospitals worked with the ministry to expand the scope of services they provided—cancer care, cardiac care, dialysis services. As such, we've been pivotal in the success of various different governments.

When the goal of government was to address fiscal pressures, the alliance hospitals were accountable to the government and patients by becoming even more efficient and cost-effective. They pursued and achieved clinical and operational efficiencies while ensuring that care was not compromised. These achievements mean that the alliance hospitals are now some of the most efficient in Ontario and that, along with the other Ontario hospitals, we have made Ontario's hospitals the most efficient in Canada.

When the goal was to raise funds to augment government capital funding for much-needed hospital redevelopment and construction that was essential to bringing services closer to home, the alliance hospitals, through their boards and foundations, raised millions of dollars over the last five years.

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All of this is to say that, like the government, we have listened; we have heard what the government expects of us, we have responded and we have been answerable. And we will continue to work in collaboration and partnership with the various governments, because that is the public trust placed upon us. This is what is expected by Ontarians: to have timely access to quality health care services that are close to home.

Which brings us to the topic at hand, Bill 8. This bill, which seeks to maintain Ontarians' access to high-quality health care, could instead begin a process that erodes the trust and partnership essential to achieving the goal of increased access to care and shorter wait periods. It is a bill that seeks to enhance accountability, but in doing so, may instead serve more to weaken the collaboration between government and health care organizations.

Today, we would like to convey our concerns and offer our suggestions pertaining to three key aspects of the proposed legislation:

First, with respect to Bill 8's proposed definition of "public interest": As currently written, it fails to make the connection between public interest and timely access to health care services. As drafted, the bill's definition of "public interest" in section 20 makes no reference to the need for timely access to health care services. In comparison, the Public Hospitals Act, clause 9.1(1)(d), clearly refers to "accessibility to health services where the community is located," when defining "public interest."

Further, while public interest must be considered when the minister exercises authority under all parts of Bill 8, there is no explicit requirement in the act for the minister to take public interest, including timely access, into account before acting. Public interest should always be the basis for the minister to act when proposing to enter into an accountability agreement or issuing sanctions against a hospital, as per sections 21, 26.1 and 27.

Therefore, the GTA/905 Healthcare Alliance recommends that the definition of "public interest" in section 20 should be amended to include specific reference to "timely access to health care services on a local basis," making the definition of "public interest" in Bill 8 consistent with the Public Hospitals Act.

Section 21 of Bill 8 should be amended to explicitly specify that when the Minister of Health and Long-Term Care intends to enter into an accountability agreement with a health resource provider, he or she must consider the public interest, ie the public's expectation of timely access to local health care services.

With respect to the proposed imposition of accountability agreements, section 21: As Bill 8 is currently worded, accountability agreements can be unilaterally imposed on a hospital if an agreement is not signed within a 60-day period by using compliance directives. This provides the Minister of Health and Long-Term Care with the authority to impose an accountability agreement on a hospital without full discussion or mutual agreement.

We believe that the potential for the minister to act unilaterally by imposing accountability agreements on hospitals usurps the role of the voluntary hospital board. Our hospital boards have always acted in the best interests of their communities, and they continue to do so. Our boards take into account and respond to local health care needs, respond to the concerns raised by the Ministry of Health and Long-Term Care, operate within the constraints of limited funding, address staffing issues and work in support of the hospital foundations' goals to raise funds.

Accountability agreements, as defined in section 19, deal with a wide variety of topics and issues, and under section 19, clause (a), can be expanded to include any other prescribed matter. Therefore, accountability agreements provide the Minister of Health and Long-Term Care with all-encompassing and centralized powers over an extremely broad array of issues. This has the potential to deny hospital boards and the public their historic role to make and influence decisions affecting their health

care services based on local health care needs and other circumstances.

To respect the historical collaboration between hospitals and government and to maintain local participation in decisions affecting local services, where accountability agreements cannot be voluntarily negotiated between the minister and the health resource provider, the GTA/905 Healthcare Alliance supports recommendations for a time-limited dispute resolution process led by a third party. We believe a dispute resolution process, by its very nature, creates a more democratic negotiation process, where both parties can work together to achieve a solution in the best interest of the community.

Therefore, the GTA/905 Healthcare Alliance recommends that subsection 21(4) should be removed from the legislation and replaced with a mandatory 30-day, third party, arbitration/dispute resolution process. This will allow a more thorough review of local health care needs and service capacities in order to shape the contents of accountability agreements.

Third, maintaining accountability between hospital boards and their CEOs: Bill 8 inherently creates a conflict of interest, because it establishes a dual accountability for the CEO to both the hospital board and the Minister of Health and Long-Term Care. The CEO is placed in an untenable position of having two masters, both with the power to take punitive measures: The board has the power to fire the CEO; the minister, under paragraphs 1 and 2 of subsection 26.1(6), has the right to hold back, reduce, vary or redirect the compensation of the CEO. This undermines an effective local governance that has well served the public for decades and continues to work well today.

If the intent of the government is to create an environment that fosters change and improvement, we wish to point out that research shows that punitive measures are ineffective in successfully improving clinical or operational hospital performance. The OHA recently released the results of the task force on operational reviews and supervisor appointments. This report makes clear that intrinsic rewards for health care professionals and health system leaders are most effective when seeking to bring about change and improvement.

We would also like to note that dual accountability, potential conflict of interest and punitive measures in the bill have the potential for creating serious CEO recruitment and retention issues for hospital boards. Therefore, the GTA/905 Healthcare Alliance recommends that subsection 26.1(6) be removed in its entirety.

In summary, we fully support the concept of increased accountability. However, as currently proposed, Bill 8 damages the existing, functioning fabric of hospital governance and undermines the relationship between boards and their CEOs. At a time when we collectively are seeking to bring about systemic changes and improvement for the benefit of the patient, we would prefer to focus our energies on integrating the delivery system, enhancing the partnerships and collaboration, thereby ensuring access and delivery of quality care close to home.

Thank you for the opportunity to participate in this round of hearings and to share with you our thoughts. We feel this is a very important piece of legislation. For it to work and to achieve its goals and objectives, it is essential that it be right, reflecting the real world in which we all work and, most importantly, where we all could be patients, and that it build upon the successful partnerships and collaboration between the government and the hospitals.

At this point, I would be happy to take any questions.

The Chair: We have four minutes remaining. We will start with the government side.

Ms Wynne: It seems to me that Bill 8, as it's written, is based on an assumption of goodwill on both sides, and so that successful collaboration and co-operation is what's assumed in the 60-day negotiation period, where the needs of a community can be brought to the table in the negotiation with the ministry. I guess I'm not clear how this 30-day arbitrated process is a better one. In the hierarchy of decision-making processes, the most sophisticated is the one-on-one, the two parties sitting down. An arbitrated one is a less free process. So how is this a better process? I'm not understanding that.

Mr Corkery: In my other life, I do a little bit of mediation and arbitration, so allow me, if I can explain. Not everybody sees things from the same perspective. With two parties, both believing they are right, both believing there is only one right way, bringing a third party who can provide different perspectives independently allows both parties to see new possibilities and come to a meeting of the minds. Basically, by doing a third party, you get the independent and you will have it happen. I believe it is possible to do it within the 60 days as outlined in the legislation. By adding an extra 30 days, it's quick. Bringing in the third party means it will be independent, and everybody then can look at it and ultimately blame the arbitrator.

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Ms Wynne: Is your 30 days on top of the 60 days?

Mr Corkery: Yes, it is.

Ms Wynne: That wasn't clear to me. Thank you.

Mrs Witmer: I'd just like to ask you, which amendment do you think is most critical to the success of the accountability agreements and the quality of health that's going to be provided for people in the province?

Mr Corkery: The one I have the most concern with right now is the way in which the minister cuts between the board and the CEO and affects the relationship, because the impact of that is unknown at this point, but it undercuts and undermines existing relationships.

Mrs Witmer: I think you point out there's some concern about even being able to attract CEOs to the position.

Mr Corkery: Yes.

The Chair: We have half a minute. If you have one half-minute question.

Mr Kormos: I appreciate your proposition about the additional 30 days. It's a relatively narrow time frame. It's a valuable tool, because what can happen now is, the

government can lowball or highball, whichever you wish, to force the hospital into not agreeing and then the government imposes its will. This provides an escape valve or release valve, if you will, for the incredible pressure that could be generated during that brief 60-day period.

The Chair: That brings us to the end of the presentation, and thank you very much for your presentation. Have a good evening.

Mrs Witmer: Mr Chair, I would move a motion at this time that we would hear the delegation from the Ontario Medical Association, once we're finished at 6 o'clock this evening.

The Chair: Agreed? It's unanimous.

ST JOSEPH'S HEALTHCARE HAMILTON
ST MARY'S GENERAL HOSPITAL, KITCHENER
HAMILTON HEALTH SCIENCES

The Chair: Next we have St Joseph's Healthcare Hamilton. Once again, this is a 15-minute presentation. Any time remaining at the end will be split between the parties, and it will be the official opposition first. Welcome.

Dr Kevin Smith: Thank you very much. I'm pleased to be here. My name's Kevin Smith. I'm the CEO at St Joe's Healthcare Hamilton and St Mary's General Hospital in Kitchener. I'm also representing my colleagues today from Hamilton Health Sciences, a large hospital consortium in Hamilton.

By way of setting the scope, this is a follow-up to the board presentation made by our board chairs of the Hamilton hospitals. You'll recall that we serve approximately, as the academic health science centre for the south central part of the province, 2.5 million people. Our collective budget is in excess of \$1 billion, with over 15,000 employees and 1,000 members of the medical staff.

We'd like to be very positive about the amendments that were proposed by Minister Smitherman and the standing committee. We believe the changes address the concerns raised by Hamilton's hospitals in the first round of public hearings for the most part.

I would like to reinforce that the minister's action in the public interest is an incredibly important endeavour in this legislation. Similarly, the minister's direct relationship with the board rather than with the CEO was well supported by our local governance structures and, of course, the mutually agreed-upon accountability agreements with mutual negotiation, something that we would certainly echo.

Some additional recommendations the committee may wish to consider: While not an easy task, the concept of rewarding both clinical and fiscal performance and incentivizing practice is an incredibly important part of this legislation or perhaps other legislation; similarly, some clear criteria for dispute resolution. As I know you've heard repeatedly, the parties need to be included

and timelines for resolution should be expected and honoured.

Perhaps a point of process: My understanding is that the Ontario Hospital Association and others have suggested that they might offer input into the skills and abilities and possibly name individuals who would be mutually beneficial in the resolution of conflict, and we would certainly support that model.

Some additional recommendations the committee may wish to consider: One that came up in our discussion with some of our local governing bodies was the clause ensuring that the minister will receive the necessary support from other branches of government in order to deliver on the commitments to hospitals. In discussing this with some previous elected officials, the challenge of shepherding this, as well as the relationship with Management Board and possibly other branches, was highlighted as an important endeavour. This is legislation not only to be lived up to by the minister but to be lived up to by the government.

A narrow range and purpose for the hospital-to-physician payments would be something we would also significantly like to see. We believe that physician issues need to be dealt with locally or regionally or through the Ontario Medical Association. As you know, those negotiations with government are currently underway. Narrowing this, in my opinion, also offers the reduced challenge, especially at times of significant physician shortage and a volatile marketplace. So, as hospitals, the ability to work more closely with our physicians and have a narrower scope of remuneration outside those of the hospital insurance plan would be something we'd very much like to echo.

Some enablers that we would suggest: Recognize that the rate and volume model that has been offered in Ontario is a blunt instrument. I heard Dr Kits mention this earlier. We really do need to look at additional markers and regressions, and we need to develop those jointly with the government of Ontario, as well as with our academic colleagues, both in Canada and abroad.

Similarly, the opportunity to learn from and work closely with colleagues who have been through this before—not unlike those in British Columbia. I'm sure you've seen the Auditor General's report on performance agreements in British Columbia. That was an incredibly important piece of work and our advice strongly would be to not miss the opportunity to learn from the work of others and improve upon it.

Similarly, the United Kingdom has been through a number of these initiatives, including a focused initiative on wait times. We also believe that there's a great deal of learning opportunity to leverage from our colleagues in the UK.

Lastly, as I listened to some of the discussion here today, I heard a lot of discussion about the issue of the CEO and the board and the minister, but underlying that I believe there must be some issue around board performance. If CEOs are performing in an abhorrent manner, obviously the intent would be for boards to act. We wonder in Hamilton about perhaps the model of a

governors' college, ensuring that our governors really do best understand the role of governance and similarly hear directly from the minister the expectations that they should be fulfilling beyond those which we as CEOs offer to them in our day-to-day existence. I would strongly encourage, as would our hospital governors, the evolution of a modern governance college, the evolution of modern governance models and collaborations and a model in which governors collectively do hear from government not only through the arms of those they employ on the day-to-day.

In conclusion, we certainly support the intent, purpose and principle of the bill. Accountability on both sides is an incredibly important endeavour. A number of us believe, having balanced our budgets in the past and into the future, that accountability has been a part of the system so far and we should certainly recognize that. That doesn't mean we can't improve upon it; we certainly can.

Hospitals welcome clear lines of accountability and, inasmuch as this legislation can help to clarify those, that will be an important step forward. Certainly we in Hamilton and Kitchener have been pleased with the amendments that the minister and the standing committee have proposed so far.

Once again, the bill needs to recognize the commitment of the government of Ontario and tie into that not only performance agreements but multi-year stable funding. Thank you very much.

The Chair: We have nine minutes remaining.

Mrs Witmer: Thank you very much, Dr Smith, for your presentation. As you heard from some of the other presenters, this need for stable multi-year hospital funding is going to be imperative if we're to put these agreements in place.

I really like your idea of a governors' college. I think it is important that everybody understands the expectations that are placed upon people in that position.

I wonder if you could just share with us: You talked about the need for the committee to consider the concept of rewarding clinical and fiscal performance. What do you mean, and why do you think that's a good idea?

Dr Smith: I believe as we look currently to the literature and the evidence that's being formed in our academic health science centres in Canada and beyond that oftentimes we may be incentivizing more service rather than looking perhaps earlier in the disease process to talk about, are we in fact preventing illness?

As we all know, the government of Ontario has currently explored the idea of improving on services for diabetics, but what about looking at a community and beginning to recognize that if we have a lower incidence of diabetics requiring admission to hospitals, we are (1) improving the health of the population, most importantly, (2) using the scarce resources of hospitals most efficiently, and (3) limiting that disease process in individuals.

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Beyond that, to be crass, in the past what seem to have been rewarded have been deficits rather than balanced

positions. While we can make statements to the contrary, while in no way casting aspersions on those who have unique situations and have been unable to do so, it only has to happen for so long before those who have tried to balance their books—a balance of rewarding those who have lived within their means as well as recognizing those who have special pressures would be important.

Mrs Witmer: Thank you very much. I would agree with you that we have been, unfortunately, rewarding deficits. What do you believe we can learn from, for example, the United Kingdom in particular? Is there something they've done that we really need to take a good, hard look at?

Dr Smith: I think a number of things; we all have to look very closely at the health human resource planning that's before us. Crassly, we simply are not training enough physicians, nurses and others now. Just to focus on medicine for a moment, general internal medicine in our country and general internists are the backbone of most emergency rooms, all medical programs in almost every hospital I could think of. We qualified two in Canada this year. The majority have gone to subspecialty training. I would suggest one issue is, how do you incentivize services where we need those skills, abilities and people? Second, I believe it's high time to recognize that extended-role nursing is an incredibly important part of our health human resource planning now and well into the future. Physician issues are not always going to be thus.

Mr Kormos: Thank you kindly, sir. One of the comments you make that's consistent with that of so many other presenters—at least during the period of time when I've been filling in for Shelley Martel here—is about the need for a dispute resolution mechanism. That's what you're referring to, I trust, under additional recommendations.

You heard the presenter just prior to you talk about a 30-day time frame. I suppose what he's really talking about is mediation/arbitration within that 30 days. You see, you've got a 60-day time frame, and if the hospital doesn't acquiesce to the government's terms, then the government imposes the terms. That isn't even a framework for negotiation, is it?

Dr Smith: Probably not, but I would have to confess that I'm not sure I feel I could get to negotiate my budget currently with the ministry.

Mr Kormos: It's even more interesting, because one of the problems here, of course, when you're talking about wanting broader government support for the Minister of Health to be able to fulfill his or her commitment—you're talking about treasury and Management Board, people like that. My fear, and I don't know if you were here earlier: This budget is coming on May 18 and the government needs the provisions in Bill 8. Remember, we had three very brief public school boards in the province that stood up to the last government, who were prepared to say, "No way are we going to become tools of a government that has abandoned education funding." Ms Wynne knows all about it. Those boards stood up

with great courage. Mind you, they were suppressed, like the tanks moving into Budapest. The Tory government moved in with their surrogate board hacks. My fear is that this bill is all about suppressing the rebellion that's going to take place among grassroots—good, well-meaning, serving board members—when they learn what this budget holds in store for public health care. Maybe I'm wrong—I hope I am—but on some of these things I've been bang on.

Dr Smith: Should I try to respond to that?

Mr Kormos: Sure.

The Chair: You have a minute.

Dr Smith: There are I guess two issues. In my opinion, if we are at the point of needing either arbitration or dispute resolution, we, as partners, have failed. One would assume that well before this, that would occur. In my recent past, I've had the experience—I don't know that it's been the pleasure—of serving as a ministerial supervisor in another hospital. I believe no one ended up happy there, including the minister. At the end of the day, people want these issues to be resolved locally. For the most part, I believe they shall be. I'm interested in ensuring that we are left with legislation that supports the delivery of quality patient care in an efficient and effective model and does not undermine local governance, while also respecting that he who pays the piper calls the tune.

Ms Smith: Thank you very much, Dr Smith. We really appreciate your being here. I wanted to ask you two quick things. One, my colleague Mr McMeekin tells me that you speak eloquently on the need for stable multi-year funding. The minister has spoken about that as well, and I wondered if you could elaborate for a moment or two on the need for stable multi-year funding and how that will improve your ability to perform.

Dr Smith: Certainly.

Mr McMeekin: The plan.

Dr Smith: The plan. As we look forward and look at the demography in our communities across Ontario, I think we certainly see not a decline in those who will be in need of service, be that in their last six months of life or not. So while we may be pushing the envelope in terms of survival and pushing life expectancy, the reality is that the last six months of life are certainly among the most expensive in the care process.

That having been said, I believe that in order to plan ahead, in order to balance our budget on a rolling cycle, we need to look at what kinds of models we might implement. As an example, do we want to capitalize a very resource-intensive endeavour? I'll give one example that our hospital has looked at: a robot, for lack of a better term, in our pharmacy services to provide intravenous mixes. It's a very expensive endeavour, yet if one looks down the road, the endeavour might also find us some operational savings at a time when pharmacists are also in short supply. So looking at a rolling cycle, it would very much allow us to do some better human resource planning.

What challenges us in that endeavour is the ongoing debate around whether or not labour settlements would,

should or could be addressed by government. While I think the historical approach has been that labour settlements are not addressed by government, it really is unrealistic to believe that the ONA settlement, the OPSEU settlement and the CUPE settlement don't have significant impacts on hospital budgets. I think perhaps being frank about what the pressure points are and also being frank about where we actually have the capacity for efficiencies with capital investment would be a great move forward with multi-year funding.

Ms Smith: Right. My second question, very briefly—I believe you were in the room for the presentation by Dr Kitts from the Ottawa Hospital.

Dr Smith: I was.

Ms Smith: I was intrigued by his ideas of the regional context for negotiating accountability agreements for various institutions. I just wondered how that would apply in your situation. I notice you're here on behalf of a number of health service providers, and I just wondered, in the regional context, how that would affect you or if you think that's a positive idea with respect to accountability agreements.

Dr Smith: Absolutely. I think it's an incredibly positive view. I think Jack Kitts and his colleagues in Ottawa have tried and succeeded in partnering with many small hospitals. We're undertaking that endeavour in our region as well. Similarly, a relationship between Hamilton and Kitchener has moved ahead. I believe that's an essential ingredient. For example, even in the absence of that full-blown plan, whatever performance agreement is decided between us and the government, I believe it would be incumbent on us to share those with our partner institutions. So in the model that says, "I'm going to reduce this service in order to balance my budget," if we and every other hospital in the region were to undertake that same reduction, I think we'd leave our patients ill at ease and, quite frankly, those physicians, nurses and others who make their living in that endeavour disadvantaged.

The Chair: Thank you for your presentation. Have a good evening.

COALITION OF FAMILY PHYSICIANS OF ONTARIO

The Chair: Next we have the Coalition of Family Physicians of Ontario. You have 15 minutes for your presentation. Should you have time at the conclusion, we'll split it between the parties for questions. Welcome.

Dr Douglas Mark: Thank you, Mr Chair. Good afternoon. My name is Dr Douglas Mark, and it's my privilege to serve as the president of the Coalition of Family Physicians of Ontario. I have to commend the committee for staying this late and persevering through this wonderfully warm day.

Dr John Tracey and I are grateful to have this opportunity to once again share our concerns about Bill 8 with you. The Coalition of Family Physicians is a member-driven, voluntary, grassroots organization representing

over 3,600 family physicians that continues to grow. It is dedicated to protecting the rights and independence of family physicians across Ontario. On behalf of our patients and members, we advocate solutions to improve our health care system and health care delivery to the people of Ontario.

To present to you our main concerns, I would now like to introduce Dr John Tracey.

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Dr John Tracey: Thank you for allowing the Coalition of Family Physicians of Ontario to present our thoughts and concerns about Bill 8 to you today.

My name is John Tracey, and I'm a family doctor in Brampton. I speak as a member of the Coalition of Family Physicians, which made an original submission to this committee back in February 2004. We welcome the opportunity for further input and comment.

From the outset, we expressed our deep concern that the impact of this legislation as it applied to physicians was so daunting and overwhelming that we would not recommend amendments but felt that the legislation should be withdrawn. We believed that it was significantly flawed. Despite certain amendments, which we congratulate the minister for making, we are still of the same opinion.

The new Liberal government, elected to effect change and sweep out the excesses of the previous regime, claims it is dedicated to democratic institution-building and improvements to the delivery of health care, yet it is renewing a process that belies their integrity when it comes down to how physicians should be treated, promotes a continuous erosion of physician freedoms and rights and may be acting in a discriminatory fashion contrary to the Canadian Charter of Rights and Freedoms.

As you are aware, there are three key components to this bill.

Part I deals with the Ontario Health Quality Council. We will not be commenting on this particular section today.

Part II, accessibility, deals most specifically with physicians and health care practitioners.

The bill as it now stands conveys what we can only describe as extraordinary powers to the minister and to the manager of the Ontario health insurance plan. Section 9 imposes the OHIP schedule of benefits upon all doctors as a sort of unilateral employment contract, without any explanation or provision as to how this document is to be negotiated and agreed upon. Exceptions have been made allowing physicians the opportunity to receive on-call stipends and other benefits that may be forthcoming from hospitals or health care facilities.

Sections 9(1) and (2) state that physicians shall not charge more nor accept payment for more than that provided by OHIP for a particular service. It removes a physician's right to bill his or her patient directly for services provided. By removing choice, this could effectively conscript doctors to assume the role of employees or dependent contractors, possibly changing their

status under Revenue Canada. Physicians would be compensated as the ministry sees fit since the government sets the schedule of payments independent of any proper bargaining process.

A ministerial order permits the minister to amend any fees or schedule of benefits, thus negating the value of any contracts that the minister may have entered into with physicians.

Coupled with the provisions in part IV, amendments to the Health Insurance Act, the right to opt out of OHIP and charge the patient directly for services rendered has been forever rescinded. Currently physicians are allowed to opt out, but are not allowed to charge any greater amount than that paid by the plan if the service rendered is an insured service. Most physicians—over 98%—choose to bill the plan, but this should not be construed as a de facto acceptance that they agree to have their civil rights infringed. Physicians have only their intellectual property to offer as a service. This bill will monopolize their intellectual property rights.

In fact, the Canadian Charter of Rights and Freedoms clearly indicates that, "Every citizen of Canada and every person who has the status of a permanent resident of Canada has the right to move to and take up residence in any province; and to pursue the gaining of a livelihood in any province." The removal of the right of physicians to opt out of the plan and set their own fees may be viewed as a discriminatory act under section 15 of the Canadian Charter of Rights and Freedoms and therefore challenged. No other group in Ontario is thus treated.

The charter goes on to say, "This court stated unanimously in Eldridge, 'A legal distinction need not be motivated by a desire to disadvantage an individual or group in order to violate s.15(1). It is sufficient if the effect of the legislation is to deny someone the equal protection or benefit of the law.'"

The shortage of physicians is a global phenomenon, and this legislation challenges the notion of attraction and retention of human resources. We believe that top-quality physicians will not be attracted to Ontario. Many will likely leave the province.

Section 10 imposes a representative body for physicians selected by the minister and permits the minister to select other bargaining agents as the minister decides. There is no acknowledgement of physicians' rights to select their own representative agent.

The Coalition of Family Physicians of Ontario objects to the provision in this act that recognizes and entrenches in law that the sole representative body for the physicians of Ontario be chosen by the government of Ontario to be the Ontario Medical Association. The Coalition of Family Physicians recently held a referendum for its membership which asked if they believed that physicians should be given the right to choose their bargaining agent. The results show that 92% of the 1,545 respondents clearly indicated that physicians should be offered a choice as to what body should represent them. This is, after all, a right of every other individual in this country.

Why would this act seek to impose a representative body of the minister's choice on physicians?

While it is not, in labour law parlance, "recognition" of the OMA as the legal bargaining agent for physicians, when read along with the exclusion in the Ontario Labour Relations Act and the practice of the government to date and for almost the past decade, it is, in effect, as close to statutory recognition as can be awarded.

Having acknowledged a representative body that would enter into negotiations on behalf of physicians and having removed the rights of physicians to bill for their services, there is no mechanism to enforce the provisions of the Canada Health Act, section 12, which provide for a legal framework for negotiations and a dispute resolution mechanism that includes binding arbitration.

From the Canada Health Act, section 12:

"Reasonable compensation"

"(2) In respect of any province in which extra-billing is not permitted, paragraph (1)(c) shall be deemed to be complied with if the province has chosen to enter into, and has entered into, an agreement with the medical practitioners and dentists of the province that provides

"(a) for negotiations relating to compensation for insured health services between the province and provincial organizations that represent practising medical practitioners or dentists in the province;

"(b) for the settlement of disputes relating to compensation through, at the option of the appropriate provincial organizations referred to in paragraph (a), conciliation or binding arbitration by a panel that is equally representative of the provincial organizations and the province and that has an independent chairman."

This is currently not what we're doing.

Physicians are denied the right to strike due to specific exclusion from the Labour Relations Act and currently have no legal framework for negotiation, no dispute mechanism and no regulations for binding arbitration. The public deserves a mechanism that ensures fairness toward physicians so that resolution can be obtained without service disruption.

Section 11 sets aside the provisions of the Statutory Powers Procedure Act and permits the manager of OHIP to make arbitrary judgments as to whether payment for a service is authorized or not. Then, based on those arbitrary powers, it empowers the manager of OHIP to declare a doctor as indebted to the plan and garnishee monies from other bona fide accounts payable to the physician.

Anyone can complain that a physician may have charged an unauthorized payment. It should be noted that the definition of what constitutes an unauthorized payment has not been defined. Given the regulatory powers of the Lieutenant Governor in Council, we will have to await this definition or, under tort law, observe developments as physicians are yet again brought before the courts.

If the manager decides that the payment was unauthorized, then he can pay back the patient and collect the payment from the physician through garnisheeing the

next OHIP cheque. If the physician asks for a review of the decision, the manager will refer the matter to the board of the Ministry of Health Appeal and Review Board. This board will appoint a reviewer of its choice to make a judgment.

The general manager of OHIP can require that the physician submit information for the purposes of determining a contravention to the act and can suspend payments from OHIP during any period where the person fails to comply, whether or not the person is convicted of an offence. We have expenses to meet. We cannot have a situation where we're not receiving any ongoing cash flow.

Section 12 limits any form of proper review of arbitrary decision and actions set out in section 11, contrary, in our view, to the principles of natural justice.

Section 16 imposes restrictions upon or limits the charging of fees for services that are neither designated as medically necessary nor are a service covered by OHIP.

We are currently self-regulated on these matters by existing jurisprudence through the College of Physicians and Surgeons of Ontario. This act would impose on the ability of the college to regulate these fees. This would include the bundling of fees for uninsured services and offering patients the opportunity to pay a one-time annual fee, otherwise known as block billing.

Section 17 imposes penalties on individuals who contravene a provision of this part of the act. These penalties range from \$1,000 to \$10,000 fines.

Section 18 allows the Lieutenant Governor in Council to make regulatory changes to virtually any part of this act and specifically to those measures outlined above.

Part III, accountability: Originally, individual physicians were to be required to sign accountability contracts. This section of the bill has now been amended to specifically exclude physicians and trade unions. Nonetheless, there are concerns that may affect physicians collaterally, especially those who work in hospitals, nursing homes and long-term-care facilities.

We note that physicians are required to sign contracts to provide care as medical directors and/or attending physicians in long-term-care institutions and are concerned about the potential for trickle-down accountability in positions to be placed in these physician contracts.

1800

There are many aspects of part III that are left to be prescribed by regulation. It is possible that the minister, through later regulations, could use Bill 8 to require hospital physician executives and/or medical staff officers, chiefs of staff, chiefs of department, presidents of the medical staff association, to enter into accountability agreements and be subject to ministry-issued compliance directives. The Coalition of Family Physicians of Ontario is concerned as to the impact on the ability of hospitals to recruit physicians into leadership positions within the hospitals.

Dr Mark: Our Liberal government ran on a platform of the politics of inclusion. We are indeed perplexed by

the contradictory nature of this bill. Physicians seek to work in peace and provide the best care for their patients. We face tremendous challenges as the physician pool, especially the family physician pool, continues to dwindle. This bill will encourage the exclusion of physicians from Ontario. The doctor shortage is global. People are willing to relocate to areas of the country, and indeed the world, that promise and deliver respect, fair play and support. We ask ourselves why the Liberal government's actions seem to belie—there's a negativity and hostility to the very professionals who seek to provide first-class health care to Ontario citizens. What have physicians done to deserve such legislation, that treats them as second-class citizens devoid of the rights and freedoms accorded to the people of Ontario and Canada?

This bill does not uphold the true beliefs and sense of fairness inherent in the Canadian context. It is wrong on moral, ethical and humanitarian grounds to continue on this path. Mr Chairman, we respectfully request a serious reconsideration of the consequences to the rights and freedoms of a specific group of people that this bill will destroy. It is not a just bill and it is not in keeping with the central tenet of the Liberal Party of Ontario. This is why we have not made specific amendments to particular sections of this bill, simply because we believe that the entire bill, as it is currently constituted, is flawed and requires a complete revision. Therefore, we believe that Bill 8 should be withdrawn immediately. Thank you.

The Chair: We have three minutes, one very quick question for each party.

Mr Kormos: I appreciate your comments. New Democrats aren't voting for the bill; we're voting against it. I have no hesitation in telling you that. But I tell you, the government needs this legislation. It needs it to suppress local hospital boards, amongst which all Hades is going to break loose after May 18 and the budget, when they see the attacks on that community-based health care. So the government is desperate. I really believe that. As I've said before, I wish I were wrong. I don't think I am on this one. We'll see.

Ms Wynne: It's nice to see you again. Thanks for coming. You've made a lot of sweeping statements. I just want to focus on the opting-out piece. I just preface this by saying that this bill is not intended to pick a fight with doctors—absolutely not. The issue of opting out, the removal of the right of physicians to opt out of the plan and set their own fees—you don't really have that right now. I understand the philosophical opt-out argument, and we've had presentations on that. But in terms of setting your own fees, the whole issue of extra-billing, Can you just elaborate on that? I don't think you have the right to do that now.

Dr Tracey: It's not a question.

Ms Wynne: Setting your own fees assumes that you'd be going above the fee schedule.

Dr Tracey: The only option that physicians have in certain circumstances, if negotiations fall down and there's no consequence on either party, because during

the course of those negotiations there's no legal framework for the negotiations, there's no binding arbitration—so at the end of these negotiations, if things fall apart, the only option that physicians may have to continue service is to opt out of OHIP and to then—

The Chair: Thank you.

Dr Tracey: Sorry?

The Chair: We do have to—

Dr Tracey: OK. So their option is to opt out of OHIP. Having had that option removed, we have nowhere to go.

The Chair: Thank you.

Mr Hudak: I think the government is trying to confuse the issues. It's not about extra-billing whatsoever; it's about a parallel system that has existed since medicare was born: a small number of doctors, mostly seniors, who are in the system. I agree with your point. At the very least, consider grandfathering these physicians.

A quick question on block fees: Is there anything in your encounters in the Ministry of Health that would give you faith that they would do a good job of administering the system of block fees in Ontario as this bill proposes to do?

Dr Mark: Absolutely none. John, can you elaborate on that?

Dr Tracey: I don't understand why the government wants to get into the business of actually taking over the regulation of block fees or fees that are for uninsured services. I do know, though, that the physiotherapists at one stage had a situation where they ran parallel fees, and now it's very difficult to get a physiotherapy treatment in Ontario that is in fact covered by OHIP.

The Chair: That brings us to the conclusion of your 15 minutes. I appreciate your attendance, and we wish you a good evening. Thank you.

ONTARIO MEDICAL ASSOCIATION

The Chair: Next we have the Ontario Medical Association. Make yourselves comfortable. Once again, 15 minutes for the presentation; if you don't use the full 15, we'll split it among the parties. Welcome.

Dr John Rapin: Mr Chairman, ladies and gentlemen and members of the committee, I want to thank you for extending your time to hear us. That's much appreciated. To that end, we will be brief.

I'm John Rapin, the newly elected president of the Ontario Medical Association. I'm an emergency physician who practises in Kingston. I also teach at Queen's, in the faculty of medicine. With me today is Dr Ted Broadway, who is the executive director of health policy at the OMA.

The OMA was pleased to see the amendments that came out of the first set of hearings and were subsequently passed at second reading. These amendments solve problems that would have arisen with regard to the payment of lab physicians, hospitalists and other physicians, and alter the accountability agreements such that important initiatives such as primary care reform can continue.

We are also pleased that the government has seen fit to continue discussion on some of the outstanding issues that we have with this bill. We will focus our comments today on a few areas where we believe some constructive changes can be made without transgressing the principles the minister made in his presentation.

The banning of opting out has been a concern to us. We have not accepted the thought that this is a necessary condition for the continuing of medicare and have seen no evidence produced by anyone that it is. There are very few physicians left in this province who are opted out, and almost all of them are senior physicians. These are physicians who perform valuable services, most of whom have practised in this style for decades. Most of them also have long-established patient lists and the patients are very accustomed to their method of practice. It would make sense to us that at the very least, if the government is determined to ban opting out, it should recognize the excellent, long-standing service of these physicians and demonstrate a desire not to disrupt their practice lives by grandfathering these physicians into the bill.

I would next turn my attention to block fees. Everyone recognizes that there are valuable services that physicians must perform for patients who are not covered by OHIP. It has become a matter of convenience both for patients and physicians to charge for these via the block fee method. In fact, physicians most likely to use block fees are full-service family physicians whose workload has become increasingly demanding over the years and who we all recognize are in drastically short supply. My belief is that we should do everything we can to ease their administrative and practice burdens. Block fees have been one way this administrative relief has been accomplished.

The way the bill is presently written would mean that immediately upon promulgation, block fees would become illegal unless the government had already written regulations to govern them. Physicians charging block fees have been very worried about the government's intentions and indeed have frequently asked me if it is possible that the government won't write regulations at all and thereby create a de facto ban without ever having to announce it.

The OMA has always felt that the charging of block fees is a professional matter, done on the private side of practice, and that it should remain entirely with the College of Physicians and Surgeons of Ontario. We believe that the government could go a long way toward demonstrating goodwill to this hard-working group of physicians by rewriting the bill in a manner that upon enactment of the bill, the college would continue to govern block fees in the absence of regulations. I believe this would allow the development of a co-operative endeavour between ourselves, the college and the ministry in the area of block fees, remove the perception of a precipitate ban, but allow the government a fail-safe mechanism into the future.

1810

Dr Ted Boadway: The last issue we will address today is the vexing situation that physicians practising

occupational medicine find themselves in as a result of this bill. When we saw this bill after first reading, it was immediately apparent that the long-standing billing practices of these physicians—billing practices as ordered by OHIP—were about to be stood on their head. A few days later, upon our first meeting with government officials, it also became apparent that this had not been contemplated and was an unintended consequence of the way the bill was drafted. I believe there is no other topic from this bill that has occupied more discussion time between the minister, the ministry and ourselves than this one. The government, however, having reflected upon this issue, will continue with this policy direction.

Occupational medicine physicians have been practising in industrial settings for years, performing an extremely valuable service that, as far as I can tell, no one contests. Most of the services they provide are clearly industrial medicine services and not insurable. However, these physicians, being in a workplace setting, will sometimes find themselves providing a service that could, in other circumstances, be billed as an insured service—for example, binding an injured thumb before sending the employee to emergency or seeing a suddenly bereaved employee before they leave the workplace. Also, there are a great number of services that clearly have a large occupational medicine component but may have a small health service component. If you look at the nature of these services, you will discover that Solomon himself, brought back to life, would have difficulty finding the plane of cleavage between what ought and what ought not to be billed to OHIP. These physicians have had many discussions with OHIP over the years, up to and including the general manager of OHIP, where they have been told categorically that they may not charge OHIP for any of the services provided in these settings. That is the way the general manager has resolved this issue over the years, and it has been satisfactory to everybody up till now. Bill 8 will require these physicians now to bill OHIP for any service that may be construed as an insured service.

Imagine that you're an occupational medicine physician. You suddenly find your contractual relationship with your employer altered, your directions for billing changed without notice 180 degrees. You never knew there was a problem because you were following the directions you had been given by OHIP and were billing appropriately, so you thought. There had never been any policy statement from the government suggesting there was a need to change billing practices completely and, in fact, there has never been an acknowledgement from the government even now that this change was being considered. Suddenly, it is in the bill.

This will require employers to collect OHIP numbers from employees and will result in a significant inconvenience in the work setting for everybody. The general manager, under section 13 of the bill, will for the first time have the power and authority to see industrial health records any time he chooses. Beginning to bill in an area where everyone recognizes there is a broad grey area will guarantee that from time to time the general manager will

be unhappy with the billings and that we will not have enough Solomons to sort this out. Physicians worry that they will inevitably be referred to the MRC. Occupational medicine physicians are understandably confused, stunned at the sudden turn, and afraid they recognize a future nightmarish scenario.

This has resulted in a credibility deficit for the ministry with these doctors. Given the way the bill is written, we are at a loss as to how to advise the government on how to get out of this accidental policy lurch through a legislative amendment. However, we do have some constructive suggestions on how it could recover some credibility with this group and find an acceptable tomorrow.

We recommend some simple things. We recommend that the ministry acknowledge that this radical change is actually taking place; that the ministry state that it values the practice of occupational medicine and has no intention of disrupting the practice itself; that the ministry recognize there will be new and increased costs in billings to OHIP which it is prepared to accept; that the ministry recognize there is a significant grey area of billings and it is prepared to be fair and reasonable in assessing this difficult area; that the ministry recognize there will be a new administrative burden imposed upon practitioners of occupational medicine.

These matters are rather self-evident and natural outcomes of the bill. We believe there can be a productive dialogue but only when the ministry acknowledges just what it is doing.

Dr Rapin: We have tried to focus today on three issues that we think can productively be amended to make the bill more workable and friendly to physicians and their patients. We look forward to seeing the amendments to this bill as you conclude your committee hearings. Thank you very much for your indulgence.

The Chair: Thank you for your presentation. We do have six minutes remaining.

Ms Smith: Thank you, Dr Rapin and Dr Broadway. Good to see you again, Dr Broaday.

I had a question about the block fees. I read through your recommendations twice, and I just want to make sure I'm clear on what you're recommending: that in the absence of regulations we allow the college to continue regulating block fees, but you're not asking us to repeal the government's right to regulate. Is that correct?

Dr Rapin: Well, the government, of course, has the right to do as it will, and we recognize that. We would prefer that this stay with the college. However, we recognize there are some concerns the government has had, and we understand why this is in the bill. We would prefer to see it out, but we understand why it's there. We would argue that allowing the college and the OMA and the ministry to solve the problem, or to at least address the problem, would make it unnecessary for the ministry to take this over.

Ms Smith: What you're proposing is kind of a stop-gap measure to allow those negotiations to take place between the college, the ministry and the OMA?

Dr Rapin: Yes.

Ms Smith: OK. But you do recognize our concerns about block fees and the accessibility question?

Dr Rapin: We may not totally agree with them, but we do recognize them.

Ms Smith: Great. Thank you very much.

Mrs Witmer: I certainly agree with your first two amendments. They seem to be appropriate and could easily be incorporated into the amendments that the government might be looking at. I guess this last one is a little more complex. You said that you've talked to the ministry and so far have not had a lot of success. What seems to be the stumbling block to resolving this issue regarding those who practise occupational medicine?

Dr Broaday: I think the biggest problem with success has been figuring out how to actually repair what's been going on, and that's been a real burden. As I say, we can't really figure out how to do that within the context of the bill. In my experience, whenever legislation is written, there is always an unintended consequence somewhere. I don't think I've ever seen one where there wasn't. The question is, can you repair it?

This is a difficult one, and I would say the discussions with the ministry have been quite productive but not in any tangible way that brings us anything yet. They now understand what the problem is; they recognize it. I think they need to make a public declaration of that, because, so far, the doctors don't know that—the very ones it's going to visit itself upon.

Last week I met with a large proportion of the occupational health physicians in this province, because we had our annual meeting and they were there. I have to tell you, this was right at the top of their minds. They're all very worried. They can't figure it out. They're totally confused. If we clarified that confusion, it would start the dialogue.

Mrs Witmer: How much additional money will this probably cost OHIP?

Dr Broaday: Good question. I don't know. I've actually put some time to try to figure out, and we just don't have a clue.

Mrs Witmer: Thank you very much.

Mr Kormos: I'm just interested. The OMA is perceived as one of the most potent professional associations in the province, certainly one of the most powerful lobby groups, the nemesis of many a Minister of Health; indeed, government. And here you are, lining up with the plain folk to make submissions to this. Did the ministry not talk to you about this bill before they drafted it?

Dr Rapin: Frankly, no. We saw the bill once it was in draft—

Dr Broaday: It had passed first reading.

Dr Rapin: OK, it had passed first reading. That's one of the problems. If we had been allowed some input earlier, I think we could have helped the ministry avoid some of the pitfalls.

Having said that, the ministry has been very forthcoming in helping us deal with our concerns.

Mr Kormos: You mean in a therapeutic kind of way?

Dr Rapin: No. As I mentioned in my presentation, I believe we have achieved a great deal to help the min-

istry repair the bill, not completely, but we have achieved some.

Mr Kormos: I just find it peculiar that you tell us you weren't one of the groups, one of the bodies consulted before the bill was first drafted. I find that very unsettling.

Ms Smith: You're unsettled, Peter.

Mr Kormos: Well, I just find it very disturbing. You should not be so complacent about that.

The Chair: Thank you very much for your presentation this afternoon. That brings us to the conclusion of our hearings and deputations.

Just a reminder to the committee: The deadline for amendments is 12 noon on Thursday, May 13. We will adjourn to clause-by-clause next Monday, May 17, at 3:30 in committee room 1.

The committee adjourned at 1821.

STANDING COMMITTEE ON JUSTICE AND SOCIAL POLICY

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First Session, 38th Parliament

Official Report of Debates (Hansard)

Monday 17 May 2004

Standing committee on
justice and social policy

Commitment to the Future
of Medicare Act, 2004

Chair: Jim Brownell
Clerk: Susan Sourial

Assemblée législative de l'Ontario

Première session, 38^e législature

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justice et des affaires sociales

Loi de 2004 sur l'engagement
d'assurer l'avenir
de l'assurance-santé



Président : Jim Brownell
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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON
JUSTICE AND SOCIAL POLICY

Monday 17 May 2004

The committee met at 1546 in committee room 1.

COMMITMENT TO THE FUTURE
OF MEDICARE ACT, 2004
LOI DE 2004 SUR L'ENGAGEMENT
D'ASSURER L'AVENIR
DE L'ASSURANCE-SANTÉ

Consideration of Bill 8, An Act to establish the Ontario Health Quality Council, to enact new legislation concerning health service accessibility and repeal the Health Care Accessibility Act, to provide for accountability in the health service sector, and to amend the Health Insurance Act / Projet de loi 8, Loi créant le Conseil ontarien de la qualité des services de santé, édictant une nouvelle loi relative à l'accessibilité aux services de santé et abrogeant la Loi sur l'accessibilité aux services de santé, prévoyant l'imputabilité du secteur des services de santé et modifiant la Loi sur l'assurance-santé.

The Vice-Chair (Mr Jeff Leal): We'll bring this meeting of the standing committee on justice and social policy to order. We're here to consider Bill 8, An Act to establish the Ontario Health Quality Council, to enact new legislation concerning health service accessibility and repeal the Health Care Accessibility Act, to provide for accountability in the health service sector, and to amend the Health Insurance Act.

I understand the government wishes to raise an issue. Mr McMeekin, please.

Mr Ted McMeekin (Ancaster-Dundas-Flamborough-Aldershot): As I understand it, some of the amendments arrived 10 minutes late, beyond the official filing, and I understand there may well be some others that might be put as we move through. In the interest of flexibility, I'd like to move that all motions that have been, to this point in time, received be part of the debate and, frankly, in the interest of flexibility, anything else that might be proposed up to the time that section is in fact to be discussed. I'll move that, Mr Chairman.

Mr Peter Kormos (Niagara Centre): On a point of order, Chair: It seems to me that a motion like that should be submitted in writing.

The Vice-Chair: I understand, in consultation with the clerk, we could do this by unanimous consent or we could ask for a specific motion to honour Mr McMeekin's—

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

COMITÉ PERMANENT DE LA JUSTICE
ET DES AFFAIRES SOCIALES

Lundi 17 mai 2004

Mr Kormos: You have a motion and I'm saying the motion isn't in order. The motion should be in writing.

The Vice-Chair: Mr McMeekin, do you have your motion?

Mr McMeekin: As part of the process—I think many members of the committee were surprised to learn this—I'll certainly write it out if that's helpful to the member opposite.

The Vice-Chair: Mr Kormos, maybe we'll just take a short recess until we get it written out and photocopied to distribute to everyone.

Mrs Elizabeth Witmer (Kitchener-Waterloo): Before we do, am I to understand that the two motions that we have that contain drafting errors and that I'm going to be filing would be included within your motion?

The Vice-Chair: I understand that's correct.

Mrs Witmer: Good. That's fine.

The Vice-Chair: Mr McMeekin, if you could just draft that quickly and we'll get it photocopied for circulation.

Mr McMeekin: I will.

The Vice-Chair: We'll have a five-minute recess.

The committee recessed from 1548 to 1603.

The Chair: Mr McMeekin, could you read this into the record?

Mr McMeekin: Yes, Mr Chair. I move, seconded by Mr Fonseca, that any amendments received up to and including the time of a vote on each section be introduced and considered by the standing committee on justice and social policy.

The Chair: Any debate?

Mr Kormos: Yes, Chair. Let's understand that I'm not aware of any constituency out there, any organization, any individual, any group or any participants in the delivery of health care who have been clamouring for Bill 8 to be passed. I have been fortunate to, from time to time, drop into the committee, which has been incredibly competently served by Shelley Martel on behalf of the NDP, and I've listened to participant after participant express opposition to this legislation. Indeed, the widest and most frequent opinion is that the government should abandon this bill entirely.

I am further distressed by the advice I've received from persons who have reviewed the anticipated amendments from the government, that there is no amendment that addresses the frequent concern expressed by participants in the hearings about the lack of dispute resolution

when there is an impasse in the negotiation of an accountability agreement between the government and a given hospital.

As I had occasion to note last week in the committee, it seems to me that the government is given the upper hand because all the government has to do is make extraordinary demands of a hospital and, when the time frame expires, the government can unilaterally impose whatever it wishes upon that hospital.

It seems to me that the prospect of dispute resolution is no longer new stuff by any stretch of the imagination. The dispute resolution process recommended by any number of participants in the hearings was a pretty straightforward one. I know there are people on the government side who are familiar with it. It struck me as being basically the sort of mediation-arbitration—the med-arb—type of model, and it seems to me eminently sensible that that would be introduced as an amendment.

The problem is, of course, that the government's amendments were not delivered in time and the committee took it upon itself to set a time period within which amendments had to be produced, tabled, filed, served upon the clerk. The government, with all of its infinite resources—well, not quite, but it seems like infinite—couldn't get their amendments in on time. New Democrats are incredibly concerned about that.

This being a debatable motion, New Democrats propose to debate it. New Democrats were well aware that unanimous consent could have resolved this issue. I'm not aware of New Democrats having been approached—

Interjection.

Mr Kormos: I'm being corrected by Ms Martel. New Democrats were approached just prior to the commencement of these hearings for unanimous consent. I want to tell you that New Democrats would love to give unanimous consent to that proposition; we'd love to. But I think in fairness, in view of the fact that the amendments were tabled late and in consideration for New Democrats giving unanimous consent—and I indicate that they are prepared to—there should be a time period permitted in which New Democrats can basically run these amendments past stakeholders and other interested parties. So I'm making it quite clear that New Democrats would give unanimous consent on the condition that this whole matter be adjourned to the next meeting of this committee.

That's why Ms Martel is preparing an amendment to this motion in writing and that's why, before my 20 minutes have expired, Ms Martel will be going out there and getting other New Democrats to come into the room to speak to it, because, as you know, one does not have to be a member of this committee. One can, as of right, by virtue of being a member of the Legislative Assembly, speak to this motion in this committee. There will be votes, at the very least on my amendment and on the amendment to the amendment. I can tell you that New Democrats will be utilizing our right under standing order 127 to seek 20-minute adjournments after calling for recorded votes.

In fact, it's with great pleasure that I anticipate that if New Democrats are compelled to speak to this motion, being that we haven't been able to agree on unanimous consent, our newest member, the member for Hamilton East, will be able to participate in this debate because she will be sworn in by the time this committee meets again, after the adjournment today at 6 o'clock.

After I have spoken to the bill, Ms Martel will be speaking to the bill—the motion. Mr Bisson from Timmins-James Bay will be coming in to speak to the motion. Mr Marchese, who is in the House right now, will be coming in to speak to this motion. Indeed, Ms Churley will be coming in to speak to this motion. In fact, the birthday boy, Mr Hampton, will be coming in to speak to this motion, and Mr Prue will be coming into committee to speak to this motion. And, as I say with great pleasure, Ms Horwath will be coming in the next time this committee sits to speak to this motion and perhaps introduce some amendments of her own.

This is a regrettable scenario. I invite the government, seeking unanimous consent, with consideration of an adjournment to the next sitting date of this committee so that we can agree to have late amendments received and deemed in order for the purpose of moving them.

1610

I've been concerned for a long time about how subcommittees take it upon themselves to create these deadlines for filing amendments. Indeed, people like Mr McMeekin may recall being in subcommittees with me on any number of committees where I've explained that the proper, in my view, approach is for the subcommittee and the committee to indicate that it is desirable that motions be tabled by a certain time but that it is not a requirement such that motions not tabled by a certain time would be excluded from consideration.

You see, what happens from time to time is that during the course of debate around clause-by-clause, the need for a motion is ascertained. When you establish this kind of time frame for the tabling of motions, it makes it impossible for a committee member to act responsibly during the course of clause-by-clause debate and to respond to concerns raised or arguments presented by presenting an amendment.

When you take it upon yourself—you know what the standing orders say. The standing orders say that a Chair "may." I don't recall—there may well have been times—in the years that I've been here where the Chair has ever taken it upon himself or herself to unilaterally set a limitation period, a time before which all motions have to be tabled. It's a bad habit of subcommittees. The people who are grossly disadvantaged tend to be opposition parties, because opposition parties, especially those that have been denied adequate resources for research and staff, find themselves harder pressed to come up with the amendments than does the government caucus.

That's why New Democrats are not in a position today to simply acquiesce to a motion of the type presented, indicating of course that the matter can be accelerated and we'd be pleased to see that done.

Some may take it upon themselves to say, "Oh, this is just a dilatory action." I say to people who would say that—

Ms Kathleen O. Wynne (Don Valley West): Who would say that?

Mr Kormos: I say to people who would say that that it's not a fair assessment of what's happening here in this committee. If you're going to live outside the law, you've got to be honest. The problem is that when you set standards like that, and you surely expect other people to adhere to those standards, then the government itself should be expected to adhere to those standards, especially when, as I say, the government has those huge amounts of resources available to it.

One of the reasons why you, of course, want to keep a limit like that, a time limitation, is because people like Ms Martel depend upon it and use it to schedule their days. So Ms Martel now is going to slip outside for a minute and telephone our caucus office, because she has to be prepared to pick up the debate upon the expiration of my speaking time. What she's going to do is slip outside to the telephone outside the door and call upon our caucus office to get in here with the one staff person I think we have, the volunteer who has been working with us. We're waiting anxiously for that volunteer to come here to the committee room and pick up the amendment and photocopy it. In fact, Ms Martel can give the amendment to the clerk and the clerk will arrange for it to be photocopied. That way Ms Martel can be ready to pick up the speech-making upon my completion.

Standing order 127, of course, is an interesting one. I recall back 16 years ago being in committee and relying upon it and seeing committee members' mouths agape because it really isn't utilized very often or very frequently, or at least hadn't been, based on the response that I received when I utilized it. It is a very effective standing order. It is one that I value a great deal. It's designed, of course, so that, prior to a vote, caucuses can effectively get their people in here. Caucuses can arrange for all the people necessary to vote.

There was a time when I was Chair of a committee where the government members didn't have enough people to move their motion. It rotted my socks for them to neglect to use standing order 127. They actually lost the vote. It was back in the early 1990s when I was chairing the committee and the government lost the vote. I was looking at them, and I didn't want to mouth the words and say, "One twenty-seven. Exercise your right under 127."

That's what happens when people don't read the rules, when people don't read the standing orders. You know, Chair, that I, being a very rule-conscious person—we live our lives based on rules. I certainly do. There are rules that I have to follow, and I do, rigorously, every day. Rules are important, and rules are, I presume, made to be kept. We fall into chaos, anarchy, if we don't keep the rules, don't we? It would be like the Tower of Babel, so to speak—procedurally, not linguistically. That's why, when you make rules like, "File your amendments by X time," you should keep them.

Sometimes there are just things that happen; there is what—the lawyer has left—I think it is called force majeure. Am I right on that, Chair? Have I got a force majeure?

The Vice-Chair: Act of God.

Mr Kormos: Force majeure.

Interjection.

Mr Kormos: Don't go playing with legalisms. You'll get the lawyers mad at you. But this isn't a case of force majeure. This is a case of, I presume, disdain for the rules, thinking, "Oh well, we're the majority, we're the government, and we can just do as we please. If we're late with the amendments, tough for the opposition."

Ms Martel was counting upon those amendments being delivered to her, being made available for her, prior to the time—

Interjection.

Mr Kormos: No, there's no problem, Ms Martel. I'm going to move the amendment and you're going to second it, right? We're working on the motion—but it doesn't matter. At the end of the day we've got enough New Democrats, especially after Hamilton East, to talk this out for a few days. When our time in committee comes back and this debate carries on, we may well be blessed with our good friend Andrea Horwath being sworn in and being capable, ready, willing and able to attend before this committee to participate in this debate.

It's an interesting scenario we find ourselves in. I don't know what the hurry is for the government anyway. Nobody likes this legislation. Nobody. They like it, and I'm not even sure all of them like it—I'm talking about the government members. I know government members, one who was on a school board, who was herself courageously assaulted by the last government. She was a member of one of the three boards across the province where the government moved in with their jackboots, stomping on the pavement and concrete, seizing that board and bringing in their political hack to run the board.

Of course, the fear of New Democrats is that we're going to see the same process facilitated by Bill 8. New Democrats look forward to co-operating with the government when the government introduces good legislation, when the government introduces good policy.

Interjections.

Mr Kormos: Look what New Democrats did—at least most of them—around Bill 31, Ms Martel reminds me. Why, New Democrats were there—I was going to say front and centre, but I'll say front and left.

Think about it. It's not as if the Liberals are the centre any more. There is no centre. The right is becoming increasingly crowded.

1620

It was delightful today, the revelations by Howard Hampton during question period, when Howard Hampton indicated, talking about the health premiums, the OHIP premiums, that the policy being enunciated by the Liberals now was the policy that had been articulated by the Tories but a couple of years ago.

The Vice-Chair: Mr Kormos, you have two minutes.

Mr Kormos: I thank you kindly, because Ms Martel is going to take up the challenge in two minutes' time, and I've got to scurry out there and find members.

Mr Kevin Daniel Flynn (Oakville): There are only eight of them.

Mr Kormos: No, there's only seven as of today, but there will be eight by the time the committee next meets. Who knows? If Ernie Eves resigns, you know, first we take Manhattan, then we take Berlin. First it's Hamilton East—

Ms Wynne: And then it's Orangeville.

Mr Kormos: And then it's Orangeville. That's right. Look, when you've got momentum, Ms Wynne, you run with it. Let's face it, Orangeville would be a feather in Howard's cap. Orangeville would be a stunning victory for New Democrats. But you'd be surprised, the kind of base we've got in Orangeville. You'd be surprised. We got members in Orangeville; I know every one of them personally. I've personally been in the same room with them.

But it's a matter of momentum, and when you've got the momentum, you should seize it. And I'm not suggesting that Ernie Eves will resign.

Ms Wynne: We know what's going to happen.

Mr Kormos: We know there's going to be a leadership convention. There's more and more participants in the leadership convention. Now there are three candidates. There could well be four. Mr Jackson's still contemplating—

Ms Shelley Martel (Nickel Belt): Elizabeth is shaking her head.

Mr Kormos: As I said to Ms Witmer, what if they form a coalition? Flaherty, Klees and Jackson form a little coalition to rule, to squeeze out Tory, the—

Ms Wynne: Triumvirate?

Mr Kormos: Yes, the classic triumvirate to rule; like a troika, like we saw after the death of Stalin—

The Chair: Mr Kormos, your time is up. I have Mr McMeekin, then Ms Witmer, then Ms Martel.

Mr McMeekin: I was just trying to be helpful. It's in my nature. When I go back to the riding, I often hear the good people I have the privilege of representing in Ancaster-Dundas-Flamborough-Aldershot—it's the riding with the longest name because our people have such big hearts and hopes and dreams. I often hear them say, "You folk down there just don't seem to get it. We've got important issues going on, health care being one of the major ones, and we want to believe that you're intelligent enough to get on with things, not to stall around."

By the way, the member from Welland, in numerous ridings that I've been in, has a reputation—well deserved, I suspect—for dilly-dallying around when we should be here working. But that's for another day.

As I say, I wanted to be helpful. I certainly wouldn't ever espouse allowing an important committee like this, one with a proud name—justice and social policy—to ever fall into chaos. That would not be my intent or the intent of any person of good will, I suspect, who wants to

move ahead with some of the important changes that we want to see.

I hope that there would be general appreciation for the fact that—I know I'm a relatively new member of the committee. I was sent over here because somebody felt that some of the giftedness that the good Lord gave me might serve on this committee. But all that aside, I've always worked from the premise that it doesn't make a lot of sense to listen to people unless you're prepared to act, and that's what this committee's called to do today: to act. We have an opportunity to move ahead, to have some of the important debate the member from the third party has noted. It just seems a shame to me that for want of 10 minutes with respect to the filing, we would bring this committee and its work to a halt.

I would note that it's interesting that the member from the third party talked about some of his serious concerns about the legislation. I find it somewhat over the top that given all those serious concerns there's not a single amendment to the bill here from the members of the third party, which troubles me. It doesn't surprise me but it troubles me. I would just note that.

I would also note in passing that, as I understand it, the Clerk's office has distributed all of the resolutions within the same timeline they normally would have been distributed. It's not like people haven't had an opportunity to reflect on them with a period of reflective time equivalent to what would normally be the case. So it seems out of all proportion that we wouldn't want to move ahead with this today.

I've always believed that we should never allow excellence to become the enemy of the good. Yes, somebody didn't get the amendments on time. Good judgment is based on experience and experience invariably on bad judgment, perhaps. We need to learn from it and try to make sure it doesn't happen again. But we shouldn't bring the important work of the Legislative Assembly and this committee dealing with an issue as pivotal as this, with so much input that we've had—really good, intelligent, thoughtful, sensitive, community-based input—to a standstill because somebody failed to get some paperwork to the clerk nine or 10 minutes before the deadline. I put it to all honourable members in this room that we should be moving forward with this as quickly as we should.

I'm never one to want to rag the puck here, but I do think it's important that we communicate as clearly as we can that we're about the important people's business here in this place and that when we talk about justice we're not talking about "just us"; we're talking about justice for all Ontarians. That requires the spirit of a willingness to be inclusive and to hear from all sides, yet you don't do that by stalling around.

I would put it to you quite sincerely that—in fact, the motion itself I think interestingly speaks to a good point that Mr Kormos raised. He often felt that in the important deliberations of committees, right up until the moment when a particular clause is voted on, there should be an opportunity to surface some issue or concern that perhaps

becomes self-evident in the context of the debate and that a process be put in place that would find and celebrate an opportunity, should we have those insights—and would it be that we would have those insights frequently in the political context that we're in—that those amendments could in fact be made.

My motion—and I'm sure Mr Fonseca, who seconded the motion, would feel equally strongly about this, wouldn't you, Mr Fonseca?

Interjection.

Mr McMeekin: Of course, the amendments are reflective, presumably—I'm taking it at face value—of the incredible giftedness of the members around this committee and their desire to do the right thing, have the right look in their eye. I guess I'm saying to the member opposite that we need to have the right look in our eye. To have the right look in our eye in this context means that we shouldn't let excellence become the enemy of the good. We should, in fact, move forward with this. We shouldn't waste the opportunity. It's said that some people never miss an opportunity to miss an opportunity. It occurs to me that that may be what's happening here. So I would hope we could move ahead with this.

Interjection.

Mr McMeekin: That's right. As my colleague says, "It's about accountability," and trying to ensure that it's there.

We won't agree on everything. I'll bet there will be some serious disagreements about some components of this legislation. My hunch is that, as we get into that in the fullness of debate, we will in fact have the kind of discussion that Mr Kormos talked about that would twig in any reasonable person's mind an obvious amendment to the legislation in the spirit of wanting to do the right thing for the people of Ontario, which would of course be substantive, because I don't think any honourable member in this room would want to move an amendment that they didn't consider to be substantive.

I would really call on us to stop and reflect a bit about what our responsibilities are and what we're all sent here to do, and I think that's to move forward with this. We've had a fairly extensive debate in the House. As I recall, Mrs Witmer, the honourable member from Kitchener-Waterloo, has been part of that. I often put my earpiece in because I don't want to miss any of her words of wisdom. I don't always agree with the honourable member, but more often than not, I do. I find her input always interesting but, more importantly, always thoughtful.

So I would hate to think that the debate that's taken place in the House that so many of us have contributed to would in fact essentially be wasted, that we would fritter away a couple of weeks simply because of some nine-minute oversight. That is, quite frankly, bizarre.

What I'd like to do is, while people collect their thoughts on this motion, which is pretty simple, just take a moment to pause. I'd like to propose at this point that we take a five-minute recess so we can all do that and come back to this in five minutes or so and continue with whatever debate seems appropriate.

The Vice-Chair: Mr McMeekin has moved that we have a five-minute recess. Agreed? Mrs Witmer, do you agree? OK, we'll just have a five-minute recess.

The committee recessed from 1634 to 1639.

The Vice-Chair: We'll resume.

Ms Monique M. Smith (Nipissing): I think we do now have unanimous consent to adjourn today's proceedings until May 31. I think we have unanimous consent for Mr McMeekin's motion, that any amendments received up to and including the time of a vote on each section can be introduced and considered by the justice and social policy committee. Is that correct?

Mr Kormos: The parliamentary assistant is correct. May I ask Mr McMeekin if he would consider amending his motion to read, "and that this committee adjourn to May 31"? If he were to do that, we could then pass that motion. It's subject to what the parliamentary assistant says, but it would combine the two goals in the same exercise.

Ms Smith: As long as I don't have to write it all out and photocopy it and give it to you.

Mr Kormos: You don't have to write it out.

Mr McMeekin: I was just thinking the same thing. I'd be pleased to make that amendment, Mr Chairman. I'll move that, the May 31 date, as well.

Mr Kormos: That the motion be amended to read "and that the committee adjourn to May 31."

Mr McMeekin: Yes. Those were my very words. You took them right off the tip of my tongue.

The Vice-Chair: We'll deal with the amendment first. All in favour of the amendment? Carried.

We'll deal with the motion, as amended. All in favour? Carried.

Ms Smith: Motion to adjourn.

The Vice-Chair: We're adjourned now until May 31.

The committee adjourned at 1641.

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Monday 31 May 2004

**Standing committee on
justice and social policy**

Commitment to the Future
of Medicare Act, 2004

Chair: Jim Brownell
Clerk: Susan Sourial

Assemblée législative de l'Ontario

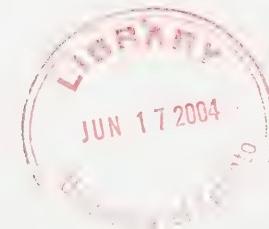
Première session, 38^e législature

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Lundi 31 mai 2004

**Comité permanent de la
justice et des affaires sociales**

Loi de 2004 sur l'engagement
d'assurer l'avenir
de l'assurance-santé



Président : Jim Brownell
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STANDING COMMITTEE ON JUSTICE AND SOCIAL POLICY

Monday 31 May 2004

COMITÉ PERMANENT DE LA JUSTICE ET DES AFFAIRES SOCIALES

Lundi 31 mai 2004

The committee met at 1541 in committee room 1.

COMMITMENT TO THE FUTURE OF MEDICARE ACT, 2004 LOI DE 2004 SUR L'ENGAGEMENT D'ASSURER L'AVENIR DE L'ASSURANCE-SANTÉ

Consideration of Bill 8, An Act to establish the Ontario Health Quality Council, to enact new legislation concerning health service accessibility and repeal the Health Care Accessibility Act, to provide for accountability in the health service sector, and to amend the Health Insurance Act / Projet de loi 8, Loi créant le Conseil ontarien de la qualité des services de santé, édictant une nouvelle loi relative à l'accessibilité aux services de santé et abrogeant la Loi sur l'accessibilité aux services de santé, prévoyant l'imputabilité du secteur des services de santé et modifiant la Loi sur l'assurance-santé.

The Vice-Chair (Mr Jeff Leal): We'll bring this meeting of the standing committee on justice and social policy to order. We're now starting the clause-by-clause review. Are there any comments, questions or amendments to any section of the bill and, if so, to which section?

Ms Kathleen O. Wynne (Don Valley West): Are you looking for amendments that have not already been presented?

The Vice-Chair: Nothing has been moved as of yet, so we'll be moving chronologically, starting now.

Ms Wynne: OK. I have an amendment to introduce to section 5, but I believe that there is an opposition amendment.

The Vice-Chair: We're starting in order, and when we get to section 5, I'll recognize you, Ms Wynne.

Ms Wynne: Fine. Thanks.

The Vice-Chair: We'll start with section 1. Are there any amendments to section 1?

Ms Shelley Martel (Nickel Belt): Chair, can I just beg your indulgence for one moment? I gather the government is moving amendments today that we haven't seen yet. So I'm just asking if we can get a copy of those.

The Vice-Chair: Absolutely.

Ms Wynne: There are four amendments that I'm introducing today, and I have copies of them.

The Vice-Chair: Thank you, Ms Wynne.

Mr Ted McMeekin (Ancaster-Dundas-Flamborough-Aldershot): I've got 39 more, Mr Chair—I'm only kidding.

The Vice-Chair: Thank you, Mr McMeekin. It's an old trick of mayors, right?

Mr McMeekin: Yes. It's the difference between the day mayor and the nightmare.

The Vice-Chair: Absolutely.

We'll now move on section 1. Any amendments to section 1? Any debate on section 1? All those in favour of section 1? Opposed? Carried.

Any amendments to section 2? All those in favour of section 2? Opposed? Section 2 is carried.

All those in favour of section 3? Opposed? Carried.

All in favour of section 4?

Ms Martel: On "Functions of Council," section 4, page 4, I just make the point that I really think that the government, to strengthen this council and to make it accountable, should have added to the functions their ability to actually make recommendations to the minister regarding what they learn through their monitoring and reporting, and that those recommendations should and could come in the form of making recommendations for funding for changes in health policy and for changes in health legislation.

The Vice-Chair: Are you moving that as an amendment?

Ms Martel: No.

The Vice-Chair: OK, just your comment.

Mrs Witmer, do you have anything you want to say on section 4?

Mrs Elizabeth Witmer (Kitchener-Waterloo): No.

The Vice-Chair: All those in favour of section 4? Opposed? It's carried.

Any amendments to section 5?

1550

Mrs Witmer: Yes. I move that section 5 of the bill, as amended by the standing committee on justice and social policy before second reading, be struck out and the following substituted:

"Reports

"5. The council shall make such reports to the Legislative Assembly as it considers desirable."

The Vice-Chair: Ms Witmer, would you like a five-minute recess to—

Mrs Witmer: No, I have it.

The Vice-Chair: The paper's right there? Sorry, Ms Witmer, go ahead. Comments on that amendment?

Mrs Witmer: I'd like to make some comments, please. Yes, the intention here is to make the council independent and ensure that it reports directly to the Legislature. This was certainly envisioned and described in the Liberal campaign platform and also the speech from the throne. The platform states that it would report directly to you on health care. Also, the speech from the throne, on November 20, 2003, says that "This independent council will report directly to Ontarians on how well their health care system is working."

Regrettably, the way the legislation is presently written, the council reports to the Minister of Health and Long-Term Care, as opposed to the people in the province of Ontario. So this would allow the council to report directly to the Legislative Assembly and to the people.

Ms Wynne: I just want to make a comment that we have an amendment—the next amendment, actually, that we're going to introduce—that would require that that report to the minister be the report that is presented in the Legislative Assembly. So, in fact, that report will come to the Legislative Assembly. I think it accomplishes the same thing.

The Vice-Chair: Further discussion?

Mr McMeekin: I'll just say that while I understand the intent and don't have a problem with the report going to the Legislative Assembly, I think the spirit of this is that the designated ministry, as a courtesy, should have the report so that they can prepare, if nothing else, answers that could logically come up in the Legislative Assembly. As my colleague, Ms Wynne, has reported, there is a provision that would ensure that the report actually go to the Legislative Assembly, as per the intent of Ms Witmer's motion.

The Vice-Chair: Further speakers on this amendment?

All in favour of the amendment? Opposed? The amendment's defeated.

Ms Wynne: This is the first motion that was just handed out. I move that subsection 5(2) of the bill be struck out and the following substituted:

"Tabling

"(2) The minister shall table the yearly report under this section in the Legislative Assembly within 30 days of receiving it from the council, but is not required to table the council's annual business plan."

Just to comment, the way the language originally appeared in the legislation, it was a report that would be brought to the Legislative Assembly. What this does is it says that the report that the council brings to the minister is the report that comes to the Legislative Assembly.

The Vice-Chair: Further speakers on the amendment?

All those in favour of the amendment? Opposed? The amendment carries.

All in favour of section 5, as amended? Opposed? It's carried.

We're now on to section 6. Shall section 6 carry?

Ms Wynne: I have a motion to section 6.1. You're just doing section 6 at this point?

The Vice-Chair: That's correct.

Mr McMeekin: On a point of order, Mr Chairman: Have we dealt with all the amendments to section 5?

The Vice-Chair: That's correct. We're now on section 6, and Ms Wynne is moving a new section, 6.1.

Ms Wynne: I just need clarification. Are we first going to deal with section 6 and then 6.1?

The Vice-Chair: Yes, that's correct. We'll deal with section 6 first. All in favour? Opposed? It's carried.

Ms Wynne: I move that subsection 6.1(11) of the bill be struck out and the following substituted:

"No review

"(11) Subject to subsection (12), a court shall not review any action, decision, failure to take action or failure to make a decision by the Lieutenant Governor in Council or the minister under this section.

"Exception

"(12) Any person resident in Ontario may make an application for judicial review under the Judicial Review Procedure Act on the ground that the minister has not taken a step required by this section.

"Time for application

"(13) No person shall make an application under subsection (12) with respect to a regulation later than 21 days after the day on which,

"(a) the minister publishes a notice with respect to the regulation under clause (1)(a) or subsection (9), where applicable; or

"(b) the regulation is filed, if it is a regulation described in subsection (10)."

The Vice-Chair: Further comment on the government motion?

Ms Wynne: I don't know if the lawyers want to comment. Do you want to make a comment on this?

Mr Robert Maisey: Certainly. Robert Maisey, counsel with the Ministry of Health and Long-Term Care. This section replicates an amendment that was made to Bill 31, which contained a similar provision. What it does is allow a limited form of judicial review where a step has not been taken under the consultation provisions, and it sets out that there's a 21-day period of time within which the judicial review application needs to be made.

Commentary had come in to the committee previously, and to the committee that was dealing with Bill 31, which suggested that subsection (11) should be amended because there was no provision for judicial review. This introduces a limited form of judicial review with a time limit.

Mr McMeekin: Am I to understand that this provision is essentially in place to guarantee the integrity of the act and that the requirements of the act can't be left undone? There would be some process that could be put in place to ensure that the intent of the act is followed?

Mr Maisey: Yes. It deals with the 60-day consultation provision. Section 6.1 sets out a 60-day consultation process. As the bill stands at the moment, there's no provision that would allow for judicial review if the

minister or the Lieutenant Governor in Council fails to follow through on that 60-day consultation provision.

Mr McMeekin: I think that's an important point, because as I recall from sitting in at a couple of the days of hearings, that was in fact raised by a number of the presenters. They were concerned about the 60-day period and the appeal process if something wasn't going the way they thought it should go. So I think it's a good provision.

The Vice-Chair: Further comment? All in favour of the government motion on section 6.1? Opposed? It's carried.

Shall section 6.1, as amended, carry? All in favour? Opposed? It's carried.

Section 7: Shall section 7 be approved? All in favour? Opposed? Carried.

Shall section 8 carry? All in favour? Opposed? Carried.

Section 9, a government motion. Ms Wynne, please.

1600

Ms Wynne: I have a motion for section 9.1.

The Vice-Chair: Correct.

Ms Wynne: So I'm assuming you'll deal with section 9 first?

The Vice-Chair: We will.

Ms Wynne: Actually, I do believe there's an opposition motion.

The Vice-Chair: There's a government motion, too.

Ms Wynne: On section 9(4). Yes. Do you want me to do that one first? OK.

I move that subsection 9(4) of the bill be amended by striking out "for rendering an insured service to an insured person" in the portion before clause (a) and substituting "for an insured service rendered to an insured person."

The Vice-Chair: Shall that carry? Any discussion?

Ms Wynne: The purpose of this is to correct the wording to ensure that third parties—for example, management companies—can't charge for insured services rendered by physicians or practitioners. This is an issue that was raised in Niagara, I believe.

The Vice-Chair: Further debate? Shall subsection 9(4) carry? All in favour? Opposed? Carried.

Mrs Witmer: I don't have a motion. I simply want to go on the record as stating that I'll be voting against section 9 for the following reasons:

I understand that there's not agreement on this particular amendment when it comes to the OMA and the OHA, and I think it's very important to look at alternative options when parties involved are at an impasse. I know that the OHA believes that the matter of payments by hospitals to physicians cannot and should not be resolved by means of legislation. So these payments are and continue to be the subject of considerable debate among the Ministry of Health, the OMA and OHA. I know everyone would like to arrive at a resolution that is appropriate, and I think that can more appropriately be done outside of this particular setting.

For that reason, we would recommend that section 9 be deleted in its entirety. What we would propose is a tripartite body of the Ministry of Health and Long-Term Care, the Ontario Medical Association and the Ontario Hospital Association, in order that work on this issue can be continued and a resolution obtained, as opposed to putting it into legislation.

Ms Martel: If I might follow up with that, we went from a position in the first draft of this bill to essentially not allowing for any payments, and we had a number of presenters in the first round of hearings who came forward and gave examples of how that would eliminate an arrangement that had already been arrived at in a particular hospital. Windsor was one, for example, I believe.

Then we went to a position when we dealt with the clause-by-clause, a change that essentially opened the door to the possibility of any number of payments. My recollection of the OHA's presentation to us after that revision was that what it was going to do was open the door now to, if I paraphrase their words, really upping the ante among some physicians who would see this now as an opportunity to look for ways and means to have other services that they provide for in a hospital covered.

I worry about that, because I've seen the ministry struggle on more than one occasion, for example, to keep physicians in emergency rooms, particularly in northern Ontario, where a number of hospitals are understaffed. That has, in some cases, caused significant problems for hospitals' global budgets, for example. I think we do have a problem here. I also understand from the OHA that they don't believe this has been worked out yet. I would much rather see us in a position where we find some way to resolve it so that we are not in a position, because of this particular provision, of having hospitals trying to find money for alternative payments in their budgets in a way that they're not now having to do.

I like what Ms Witmer has put forward, and I think the government might want to take second look at this and what its implications are if it goes forward in the way it's currently drafted.

The Vice-Chair: Further debate?

Shall section 9, as amended, carry? All in favour? Opposed? Carried.

We're now dealing with section 9.1.

Ms Wynne: Yes. I've distributed a motion on section 9.1. The motion that members already have in their package needs to be withdrawn, and the one you were just handed is the replacement. The motion on page 5 in your package is being replaced by the motion that I just distributed. Is everybody with me?

The Vice-Chair: We're with you. Continue, Ms Wynne.

Ms Wynne: I move that we replace subsections 9.1(1) through (7) with the following:

"Transitional

"9.1(1) This section applies to physicians and designated practitioners who, on or before May 13, 2004, have rendered insured services to insured persons and who had

never notified the general manager of their intention to submit accounts for the performance of insured services rendered to insured persons directly to the plan in accordance with subsection 15(1) or 16(1) of the Health Insurance Act, or had notified the general manager under subsection 15(4) or 16(4) of the Health Insurance Act that they intended to cease submitting their accounts directly to the plan.

“Notification”

“(2) If a physician or designated practitioner mentioned in subsection (1) notifies the general manager by registered mail, within 90 days of the coming into force of this section, that he or she intends not to submit his or her accounts directly to the plan, the provisions of subsection (7) apply to him or her.

“Transitional time”

“(3) Subsection 9(2) does not apply to a physician or designated practitioner mentioned in subsection (1) who does not give notice under subsection (2) until the first day of the third month following the expiration of the 90-day period under subsection (2).

“Subsequent election”

“(4) A physician or designated practitioner who has notified the general manager under subsection (2) may subsequently notify the general manager by registered mail that he or she intends to submit his or her accounts directly to the plan for the performance of insured services rendered to insured persons and in such a case, subsection 9(2) shall apply and the physician or designated practitioner may not subsequently choose to cease submitting his or her accounts directly to the plan.

“When decision takes effect”

“(5) A decision to submit accounts directly to the plan under subsection (4) takes effect as of the first day of the third month following the month in which the general manager received the notification.

“Deemed election”

“(6) Unless the general manager is satisfied that the account was submitted in error, if a physician or designated practitioner who has notified the general manager under subsection (2) subsequently submits an account directly to the plan for the performance of insured services rendered to an insured person, he or she shall be deemed to have notified the general manager under subsection (4) that he or she intends to submit his or her accounts directly to the plan, except in respect of any prescribed accounts or classes of accounts, and subject to any prescribed circumstances or conditions.

“Where notification given”

“(7) The following apply to a physician or designated practitioner who has notified the general manager under subsection (2), except in respect of any prescribed accounts or classes of accounts, and subject to any prescribed circumstances or conditions:

“1. Subsection 9(2) does not apply to the physician or designated practitioner, and despite subsection 9(4), he or she may accept payment for the rendering of insured services to insured persons from a source not mentioned

in clauses 9(2)(a), (b) or (c), if he or she complies with all other relevant provisions of this part.

“2. Subject to subsection 9(1.1), the physician or designated practitioner shall not accept payment for rendering an insured service to an insured person until after he or she receives notice that the patient has been reimbursed by the plan unless the insured person consents to make the payment on an earlier date.

“3. All other applicable provisions of this part apply to the physician or designated practitioner.”

This new section grandparents physicians and designated practitioners who, on or before May 13, 2004, did not submit their accounts for rendering insured services to insured persons directly to OHIP. This deals with the opt-out situation we've talked about a number of times in this committee. This clarifies how practitioners should proceed.

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The Vice-Chair: Thanks very much, Ms Wynne. Debate?

Ms Martel: I have a quick question. The changes appear to be around the transitions moving from 16(4) to 16(1) of the Health Insurance Act. Is that the change?

Ms Wynne: Can we get legal counsel to clarify that?

Ms Jennifer Wilson: There was a reference to 15(1) of the Health Insurance Act. We added a reference to 16(1); 15(1) deals with physicians and 16(1) deals with practitioners. It was just an error there.

The Vice-Chair: Could you identify yourself for Hansard?

Ms Wilson: I'm Jennifer Wilson, counsel with the Ministry of Health and Long-Term Care.

The Vice-Chair: Thank you very much.

Ms Wilson: I can give you more of an overview of the provisions if you'd like.

Ms Martel: I looked through the whole thing and that seemed to be the only area where there was a change. I wasn't sure what the reference was to have the section put in again but with a different number.

The Vice-Chair: Any further debate?

Shall section 9.1 carry? All in favour? Opposed? Carried.

We're now dealing with section 10. Shall section 10 carry? All in favour? Opposed? It's carried.

Shall section 11 carry? All in favour? Opposed? Section 11 is carried.

Shall section 12 carry? All in favour? Opposed? It's carried.

Shall section 13 carry? All in favour? Opposed? It's carried.

Section 14: Ms Wynne.

Ms Wynne: I move that subsection 14(3.1) of the bill be amended by striking out “prescribed time” and substituting “period of time.”

This is a question of cross-referencing. The language was changed in one place and not in another.

The Vice-Chair: Ms Wynne has moved the amendment. All in favour of the amendment? Opposed? The amendment carries.

Shall section 14, as amended, carry? All in favour? Opposed? It's carried.

We're now on section 15. Shall section 15 carry? All in favour? Opposed? Section 15 is carried.

Section 16: Ms Wynne, please.

Ms Wynne: I move that subsection 16(1) of the bill be struck out and the following substituted:

"Block fees

"(1) If regulations have been made under this section, a person or entity may charge a block or annual fee only in accordance with those regulations."

This retains the status quo until regulations are written around block fees, and therefore addresses the concern about that interim period. I think some people may have heard that concern that was brought to us by the OMA.

The Vice-Chair: Debate on this one?

Mrs Witmer: Just for clarification, does this amendment mean that the college will continue to regulate block or annual fees until the regulations have been developed?

Ms Wynne: What it means is that the status quo will pertain until the regulations are written.

Mrs Witmer: Then can you answer my question specifically? Will the college continue to regulate block or annual fees until the regulations—

Ms Wynne: I'll have legal counsel speak to this, but there is actually nothing in legislation that gives the college the right to regulate block fees. It has been rather an ad hoc situation, and that's what we're trying to clarify in the legislation. Does that answer your question, or would you like to hear—

Mrs Witmer: No, it doesn't.

Ms Ella Schwartz: I'm Ella Schwartz, counsel for the Ministry of Health and Long-Term Care. It doesn't take a position on whether the college can regulate block fees or not; it just says that whatever the status quo is, we're not changing it.

Mrs Witmer: What is the status quo?

Ms Wynne: Sorry, if I could speak, there are guidelines. I think we heard many times that the college has guidelines in place, but that's not a regulatory function. That status quo of those guidelines will pertain until the regulations are written.

Mrs Witmer: But in essence what you're telling me then is that until such time as they are developed or written, basically nobody is responsible for regulating.

Ms Wynne: What we're telling you is that the situation that pertains now is going to pertain until the regulations are written.

Mrs Witmer: But people don't know who is responsible for regulating these fees in the interim while the regulations are being drafted.

Ms Schwartz: The college has guidelines in place. It is possible that they have regulation-making power, but we don't really know what the court would say. There was a block fees regulation made by the minister that the court said didn't work. If the college brought forth a block fees regulation and it were challenged, the court would look at it and make a decision on that particular

block fees regulation, whether it was authorized or not. We thought our regulation was authorized and the court disagreed with us, so we can't really say what would happen if the college made a block fees regulation.

Ms Wilson: It's my understanding they don't have any specific power respecting block fees.

Ms Schwartz: They have professional misconduct power, and it's hard to know exactly what the limits of the professional misconduct power are without bringing a specific regulation forward to the courts. But of course, when a college makes a regulation, it's law until it's challenged and struck down. So that's why we can't answer you; we have to wait for the courts.

Mrs Witmer: Sure, and I appreciate that, but I guess what we want to make sure happens is that there is a smooth transition here during the time of passage of Bill 8 and the development of the regulations. I think it's really important that everyone clearly understand, particularly those in the medical profession, the status and the guidelines around block or annual fees. I don't find this amendment makes any clarification.

Ms Wynne: I know my colleague wants to say something as well, but I think the fact that there hasn't been anything more explicit in legislation until this point means there is some clarity within the profession on what the guidelines are. They've been functioning. The previous government didn't introduce anything that clarified the issue, so the status quo will pertain until the regulations are written. I think that does deal with the transition; that's exactly what this amendment is intended to do.

Mrs Witmer: I'll have to trust you, Ms Wynne.

The Vice-Chair: The speaking order is Ms Martel and then Mr McMeekin.

Ms Martel: On a practical level, if a constituent has an issue about a block fee, do we tell them to use the discipline process at CPSO or do we tell them to deal with the Ministry of Health in that regard? It's just on a practical level, because they deal with complaints about block fees. Who do we refer people to in the interim?

Ms Wilson: Before regulations are passed for Bill 8?

Ms Martel: Back to CPSO?

Ms Wilson: CPSO.

Mr McMeekin: It seems to me that there are issues worth fighting over and some that aren't. My old martial arts training always taught me you don't go picking fights when you don't need to. It seems to me this is a contentious issue. I think we need to be saying to the ministry, regardless of what we're saying to anybody else, get on with putting those regulations in place, but in the meantime we'll have peace in the land and we'll get on and provide good, quality health care to people, and sooner, rather than later, we'll have these regulations come forward that will sort it out definitively once and for all.

The Vice-Chair: Further debate?

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Ms Martel: I have another question. The process for this regulation-making will be the one that's already

described in the bill, which will be a public process. What is your intention around the timeline for these particular sets of regulations?

The Vice-Chair: Could you identify yourself for Hansard, please?

Mr Thomas O'Shaughnessy: I'm Thomas O'Shaughnessy, senior policy adviser, Ministry of Health and Long-Term Care.

Ms Martel, could you repeat your question, please?

Ms Martel: Because of the lack of clarification around this area, I'm assuming you're going to use the more public process for regulations that's listed in the bill that we've amended already. But what is the ministry's time frame around these particular regulations dealing with block fees?

Mr O'Shaughnessy: We're certainly going to be consulting with the CPSO. We've already been in communication with the CPSO and the dialogue is very open. So we're going to be in dialogue with them over the course of this summer, the next couple of months, to ensure that the regulation is developed in a very timely and comprehensive way.

Ms Martel: Has the ministry set a deadline for that?

Mr O'Shaughnessy: The ministry has set no definitive deadline, but obviously as soon as possible.

The Vice-Chair: Further debate?

Mr McMeekin: I just want to say that it's a whole new approach. And with reference to Ms Wynne, if you can't trust Ms Wynne, whom can you trust?

The Vice-Chair: Very philosophical.

Shall government motion 61 carry? All in favour? Opposed? It's carried.

Ms Wynne, government motion 16(4), please.

Ms Wynne: I move that subsection 16(4) of the bill be struck out and the following substituted:

"Definition

"(4) In this section,

"block or annual fee,"

"(a) means a fee charged in respect of one or more health services that are not insured services as defined in section 1 of the Health Insurance Act, or a fee for an undertaking not to charge for such a service or to be available to provide such a service or services if,

"(i) the service or services are or would be rendered by a physician, practitioner or hospital, or the service or services are or would be necessary adjuncts to services rendered by a physician, practitioner or hospital, and

"(ii) at the time the fee is paid it is not possible for the person paying the fee to know with certainty how many, if any, of the services covered by the block or annual fee the patient will require during the period of time covered by the block or annual fee, or

"(b) has any other meaning that may be provided for in regulations made under subsection (3)."

This expands the definition of "block fee" and makes it a more comprehensive one.

The Vice-Chair: Debate?

Shall subsection 16(4) carry? All in favour? Opposed? It's carried.

Ms Witmer, please.

Mrs Witmer: I'm going to, in light of the discussion we've just had in good faith, withdraw this motion.

The Vice-Chair: That's withdrawn.

Ms Witmer, 16(5).

Mrs Witmer: I'm also going to withdraw 16(5).

The Vice-Chair: Thank you very much, Ms Witmer.

Shall section 16, as amended, carry? All in favour? Opposed? That's carried.

Shall section 17 carry? All in favour? Opposed? It's carried.

Section 18: Ms Wynne, please.

Ms Wynne: I move that section 18 of the bill be amended by adding the following subsection:

"Restriction

"(5) A regulation made for the purposes of this part shall not include a provision that is contrary to a provision of the Canada Health Act."

I think that's self-explanatory, Mr Chair.

The Vice-Chair: Thank you very much, Ms Wynne. Any debate?

All in favour of government motion 18(5)? Opposed? That's carried.

Shall section 18, as amended, carry? All in favour? Opposed? Carried.

We're now dealing with section 19. Shall section 19 carry? All in favour? Opposed? Carried.

Section 20: Mrs Witmer, please.

Mrs Witmer: I move that subsection 20(2) of the bill, as amended by the standing committee on justice and social policy before second reading, be amended by adding the following paragraph:

"11.1 Timely access to care."

The Vice-Chair: Debate?

Mrs Witmer: I guess what we would want to ensure happens is that the minister or the Lieutenant Governor in Council, when acting in the public interest, would take accessibility of care into account. Also, the inclusion of this particular amendment would align public interest in Bill 8 with the definition of public interest in the Public Hospitals Act, and this would ensure consistency.

Ms Wynne: Just to be clear, we are introducing the next motion, to add accessibility, which, actually, is broader than just timely access. So I won't be supporting the timely access.

Mrs Witmer: Well, I would respectfully disagree with Ms Wynne. The word "accessibility" simply says, "at some point in time." "Timely access to care" actually speaks to the fact that it needs to be accessible, but it needs to be accessible within, hopefully, a reasonable period of time. So I think the motion that I have proposed is actually much more definitive and, as I've said before, it is consistent. I couldn't support the next one.

Ms Martel: The key has to do with timely access to care. You don't need to have too many government reports to know that is an issue with respect to cancer treatment, for example, and many others. As the government develops a bill which they say is going to improve medicare, improving medicare means that patients who

require hip surgery or cancer treatment or a whole host of health care services get them when they need them and where they need them. So I think the inclusion of the word "timely," frankly, is critical when you're talking about people who expect and require medical care in Ontario. "Accessibility" just doesn't go far enough to deal with, frankly, what the government purports this bill will do, which is, once the health council gets up and running, monitor and report on these kinds of matters and, we hope, make funding investments in the places that will ensure that people do get access to the care when they need it and where they need it. So I would really encourage the government to have a second look at the inclusion of "timely." I think it is quite critical to what we are discussing with respect to public interest in this section.

Ms Wynne: I just want to reinforce what I said earlier about accessibility being the broader term. The word "timely" is not in the Public Hospitals Act. The whole point of this bill is to introduce accountability. Within those accountability agreements that will be negotiated with the health institutions, that's where the targets for wait times and so on will be set. So really, the whole issue of timeliness is in this bill, and accessibility is a broader term that takes in more than just timeliness, but also timeliness.

Mr McMeekin: I just want to be clear. Maybe this is one of those times when the freedom of members to speak their mind in committees—I don't think the government is saying that they don't want to see timely access for health care. I think, in part, what Ms Wynne is saying—and she is always very logical in her arguments—is that from her perspective, accountability is an inclusive term.

Ms Wynne: Accessibility.

Mr McMeekin: Oh, accessibility. Sorry. The whole thing is about accountability and accessibility. But surely, timeliness is part of that. It would seem to me that it's difficult to say on the one hand that this concept is included in the broader definition, yet excluded specifically when it may help clarify to have it included. So I intend to support the amendment, although I do so respectfully, given what Ms Wynne has said.

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Ms Martel: Can I just make one other point, Chair? I don't pretend to know all the provisions of the Public Hospitals Act, but it's not clear to me that all of the other values or characteristics that are outlined on page 23 of the bill under "public interest" are also actually outlined in the bill.

Someone's going to correct me if I'm wrong, I'm sure—and they should—but if you look at any of the other principles, we've outlined a number of principles which the minister will have as part of the accountability agreements. There are 1 to 12 here listed under 20(2). I suspect not all of those are outlined in the Public Hospitals Act, so that shouldn't be a reason for us not to incorporate timeliness here. I think it is an important principle that the minister should be taking into account

in accountability agreements. Frankly, so should the partners, and I'm sure they will be, but the use of "timely" is a much different matter than the principle that only specifically talks to accessibility. We've already got 12 other principles that are outlined. I'm not sure what the problem is about adding 13 or 14, for that matter.

Ms Wynne: We're going to get into a linguistic debate here, but to our mind, "accessibility" is the broader term. If we talk about timely access, then do we have to talk about other kinds of access—geographic access? I mean, you might have to then specify—

Ms Martel: I like that. I'm with you on that one.

Ms Wynne: I know. I thought you would. That's why we're going to use accessibility, because it's the broad term, it includes those other things and it's the more inclusive term.

Mrs Witmer: I would respectfully disagree, because you've just made a very good point. I think timely access to care would provide for those in distant geographical locations to have timely access. This means that, no matter where you live in this province, no matter who you are, you are ensured of having the same timely access to care as anybody else, whether you're in the city of Toronto or you're up in New Liskeard.

I think that's extremely important, and I think Ms Martel has made some excellent points. The reality is, folks, when someone has cancer, they don't need treatment a year or two years from now. When someone needs a hip replacement or cataract surgery, really the key is that it's just not accessibility; it's making sure it's provided in a very, very timely manner. Because in the case of some of the eye diseases, it is obviously going to have a big impact on their vision and quality of life.

The Vice-Chair: Further debate?

Ms Wynne: I'm going to rest my case.

Mr McMeekin: Since I'm out on a limb anyway, I just want to pick up on Mrs Witmer's point. My late mother had to wait 10 weeks to get a test to find out how little time she had left to live, and that was not timely health care. One of the things that I try to do every day, and I think every member here tries to do every day, is be intelligent about the decisions we make. We spent a fair bit of time in the election campaign talking about timely access to health care. So I intend to support it.

Mr Jim Brownell (Stormont-Dundas-Charlottenburgh): I just had a little discussion here, and I mentioned that very thing. We did, during our campaign, talk about timely access. I think if it's implied in the word "accessibility," then why not be up front and have it in as a word? As Mr McMeekin said, that's the reason for the support. I think the word "accessibility" is totally fine, but this gives it a little more meat. I'm going to support it.

The Vice-Chair: Further debate? Further discussion?

Shall PC motion 20(2) carry? All in favour?

Ms Martel: Recorded vote.

The Vice-Chair: All in favour? Mrs Witmer, Ms Martel—

Interjection.

The Vice-Chair: Oh, I'm sorry. I'm used to my council days when the chairman used to read out the names. Go ahead. Sorry. I didn't mean to usurp your role, Madam Clerk.

Ayes

Brownell, Craitor, Martel, McMeekin, Witmer.

The Vice-Chair: It's carried. I just wanted to give everybody an opportunity.

So we now move to a government motion. Ms Wynne, please.

Ms Wynne: Given the argument I made that this is the broader term, I am going to go ahead and move this amendment.

I move that subsection 20(2) of the bill be amended by adding the following paragraph:

"11.1 Accessibility."

The Vice-Chair: Debate?

Ms Wynne: Should it be renumbered? Yes, there's a numbering problem. If 11.1 has already been moved with this—

The Vice-Chair: It will be renumbered.

Ms Wynne: All right.

The Vice-Chair: Any discussion or debate? Ms Martel, please.

Ms Martel: I'm going to support that. It's not a problem, Kathleen. It's one more principle among many, so that's good.

The Vice-Chair: Any further debate?

Shall government motion 20(2), which will be renumbered when the bill goes out, carry? Carried.

Shall section 20, as amended, carry? Carried.

The clerk is distributing some material with regard to PC motions that really belong in section 20, but in our material they're listed under section 21. I'm sorry, is it just the opposite? OK. It should be in 21. There we go. That's correct. The clerk is distributing the right information now.

Section 21: Ms Wynne, you have a government motion?

Ms Wynne: Yes, thank you, Mr Chair.

I move that subsections 21(2) and (4) of the bill be struck out and the following substituted:

"Discussion

"(2) After the notice under subsection (1) is given, the minister and the health resource provider shall negotiate the terms of an accountability agreement and enter into an accountability agreement within the applicable number of days provided for in subsection (2.1).

"Applicable number of days

"(2.1) The applicable number of days is,

"(a) 90 days where the minister gives notice to the health resource provider under subsection (1),

"(i) for the first time, or

"(ii) for the second time, where the first accountability agreement was for a term of one year or less; and

"(b) 60 days in all other cases.

"Direction

"(4) If the health resource provider and the minister do not enter into an accountability agreement within the applicable number of days after the minister gave notice under subsection (1), the minister may direct the health resource provider to enter into an accountability agreement with the minister and with any other health resource provider on such terms as the minister may determine, and the health resource provider shall enter into and shall comply with the accountability agreement."

This clarifies and gives more time for the establishment of the accountability agreements, and we heard a lot about this from delegates.

The Vice-Chair: Debate? Ms Martel, please.

Ms Martel: This might not be quite the appropriate section to raise my general concerns about these provisions, it might be 21(1), but I'll do now anyway. Let me raise two concerns with the committee that you've heard before, but I'll do them one more time.

Number one has to do with the time frame that is outlined. I think the ministry is going to be in significant trouble very early on in negotiating these accountability agreements, because we are talking about accountability agreements not only for hospitals, and there are many of them in the province, but we are talking about accountability agreements with community care access centres, independent health facilities and long-term-care facilities.

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It's never been clear to me exactly what the ministry was going to use in terms of its agreements with long-term-care providers. For example, if they were going to try and build on the service agreements that exist—I think they're renewed annually, but in any event, I don't think the ministry will be, in any shape or form, able to actually comply itself, from its side, with respect to the sheer number of people who are going to have to be involved in the negotiation of these agreements, and frankly their capacity as well. In some of these hospitals, you're talking about millions and millions of dollars.

A program that may now be under way with the joint policy and planning committee still has to be, I think, tuned up and fixed, up to the point where it can be applicable. I would even have thought it would have made more sense for the ministry to test some of this in a pilot in a number of hospitals and in a number of community care access centres etc to see how it was going to work. I think that as soon as we get into it, the ministry itself is going to be out of compliance in terms of the time range it has outlined here.

Second—this is probably more with respect to section 21, but with your indulgence I'll deal with it now—I continue to be very concerned that the ministry has been unable to negotiate some kind of independent, third-party dispute resolution mechanism with the OHA. There has been no change in the ministry's position as far as I can tell, and that issue remains outstanding. I firmly believe it would make much more sense for the government to have an independent third party, where disputes can finally be resolved, than to have essentially the minister

in the position of issuing what will be unilateral orders or compliance directives in the event there is no agreement.

I do not understand why the government wants to be in that position, why the minister wants to be in that position. It would have made far more sense to move a little bit further down the road and to put in place a dispute resolution mechanism, whatever that mechanism might be, so that at the end of the day, it would be that independent third party issuing decisions rather than the government itself. I think this is going to cause enormous problems in a number of communities with local hospital boards, for example. I just don't understand why the government wants to be in that position, and I think that's where you will be.

Mrs Witmer: This entire section remains as one of the most outstanding contentious issues, and I would certainly support everything that has just been said by Ms Martel. I'm really surprised and very disappointed that the government has not sought to work in a collaborative manner and made some compromises, particularly with the Ontario Hospital Association. As Ms Martel has said, there is a JPPC process in place. Work was ongoing.

I've been at the Ministry of Health. I personally don't think there is the capacity to draft all of these agreements within the timelines that are being suggested. I don't think anybody understands the enormous task that is before the ministry. Are we simply going to increase the size of the bureaucracy and not achieve any savings, and I'm not sure much in the way of accountability? I am very disappointed there isn't a resolution with the Ontario Hospital Association in resolving this particularly contentious issue.

I'm also disappointed there are no pilot agreements. We used to do this all the time in education when I was chair of a board. We would test and pilot initiatives, and I have to tell you, you learned a lot. I think in this particular area we could learn a lot if we developed pilot agreements with some of the different health care providers. We could save ourselves a tremendous amount of taxpayer money and wasted energy.

Again, I'm very disappointed that there is no dispute resolution mechanism, that we're not prepared to hand it over to a commissioner or a panel of commissioners—some independent third party—because I'll say what I've said before: The accountability really goes all one way. There isn't much accountability here for the Ministry of Health or the government. So I have very serious reservations about this section.

Ms Wynne: I will just say two things. First of all, the extension to 90 days is an acknowledgement that there may need to be, especially at the beginning, a longer process. I think that, on all we heard about the need for a dispute resolution process, we're responding to it in terms of extending the period.

I think on the other piece, there is nothing in what we're saying here that would suggest that the work of the joint policy and planning committee is not going to be used. As Ms Martel said, I think that is ongoing. We're hoping that the framework they come up with for

accountability agreements will absolutely be consistent, and we expect it will be consistent, with Bill 8. So that work is already in the works. The stakeholders are at the table having that conversation.

I think this amendment is a substantial compromise, and I think it will go a long way to deal with the issues that have been raised with us.

The Vice-Chair: Further debate?

Shall the government amendment on section 21 carry? All in favour? Opposed? It's carried.

PC motion 21(4): Mrs Witmer, please.

Mrs Witmer: I move that subsection 21(4) of the bill, as amended by the standing committee on justice and social policy before second reading, be amended by striking out "the minister may direct" and substituting "the minister may, subject to the approval of the Lieutenant Governor in council, direct."

By putting this forward, we want to make sure there is an amendment that adds accountability to ensure the power to impose an agreement could only be made by an order in council or, alternatively, that it be subject to ministerial approval. As I say, this is certainly the most contentious set of amendments that remains unresolved. This is an attempt to ensure the accountability of the minister as well.

The Vice-Chair: Further discussion?

Shall PC motion 21(4) carry? All in favour? Opposed? It's lost.

Ms Witmer, 21(4.1).

Mrs Witmer: I move that section 21 of the bill, as amended by the standing committee on justice and social policy before second reading, be amended by adding the following subsection:

"Review by commissioners

"(4.1) Before making a direction under subsection (4), the minister shall refer the matter to a commissioner or a panel of commissioners who are independent of the health resource provider and the minister, and the commissioner or commissioner, if it considers the matter appropriate for review, shall review the matter and make recommendations to the minister, the health resource provider and the public within 30 days of the referral."

I'll just repeat what I've said. The legislation, as currently drafted, still allows for these accountability agreements to be imposed without referral to a third-party dispute resolution mechanism. As a result, and most regrettably, there is still power for the minister to impose anything he likes on any individual health provider, while ignoring the people within the system. We can take a look at the boards of hospitals and really take into consideration some of the priorities of the particular health provider.

This really would provide for true third-party review in a manner that is streamlined. We would still see an expedient resolution of the issue. In addition, it would provide the parties with some independent advice and give the sector information respecting how disputes over the agreements are being addressed. The commissioners would have the authority to deny a review if they felt it wasn't in the public interest to do so.

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I think what this does is ensure an open, democratic process of negotiation which would result in a fair resolution, which ultimately would be more conducive to achieving what I would believe the government would have in mind, as far as the goals and objectives that they would want set out in the accountability agreements.

I have to tell you, I'm very, very perplexed that this government in particular refuses to participate in this type of open, democratic process of negotiation that I believe would result in a fair resolution.

The Vice-Chair: Further debate?

Ms Martel: I just might add to what Mrs Witmer has just said. I think it remains impossible for the government to argue that accountability agreements are negotiated when the language in the bill shows otherwise. The language in the bill remains very clear, and that is that at the end of the day, the minister does have the unilateral authority to impose orders or compliance directives.

So two things: If the government were serious and if the minister himself were serious about his claims that these are negotiated, then the government would have been here today withdrawing those sections of the bill that still allow for the minister to have unilateral power.

For example, that would include on page 27, section 21.1(4), where it says: "The minister shall consider any representations made under subsection (3) before making a decision to issue a compliance directive or an order under subsection 26(1)."

The government would be here today removing section 22(2), page 28 of the bill, which says: "The health resource provider shall comply with a compliance directive."

The government would have been here removing today subsection 26(2), under "compliance," which says: "The health resource provider shall comply with an order issued under subsection (1)."

So while the minister says publicly that the accountability agreements will be negotiated, the language of the bill clearly demonstrates otherwise. At the end of the day, the minister continues to have all of the authority to unilaterally use his or her power to implement both orders and compliance directives upon hospitals. So there's no negotiation in that. I think the very draconian power for the minister that's in the bill is power that is not necessary and should be removed.

Again, if the government wants to get at negotiated settlements, the government would remove this language and the government would put in place a true third-party process that would allow them to get there with respect to these accountability agreements.

We heard again and again, particularly from hospital boards, that they were not averse to accountability agreements. They outlined the many ways they felt they were accountable. The government should be moving to an independent process for those times and places where you cannot get an agreement between the ministry and the various hospital boards or owners of long-term-care facilities etc.

Ms Wynne: Just two quick comments: I think the issue here is the delay in the process and the desire not to further delay the process by introducing another process on top of the one that's already outlined. I guess the other point is that the commissioner or the reviewer, whoever that third party is, is not, at the end of the day, going to be held accountable for the decisions made for core functions of the minister. Those core functions, that core job is what the minister's holding on to here, by not having a commissioner or a reviewer who would not be accountable to the people of Ontario. So that's the argument for leaving the language the way it is.

The Vice-Chair: Further debate?

Shall PC motion subsection 21(4.1) carry?

Ms Martel: Recorded vote.

Ayes

Martel, Witmer.

Nays

Brownell, Cansfield, Craitor, McMeekin, Wynne.

The Vice-Chair: It's lost.

Mrs Witmer, subsection 21(5).

Mrs Witmer: I move that subsection 21(5) of the bill, as amended by the standing committee on justice and social policy before second reading, be amended by striking out "may" and substituting "shall."

Now, what this would do is ensure a direct line of accountability between a board and its CEO. It would prevent the blurred accountability between the CEO and the board.

As you know, we heard over and over and over again that this bill, Bill 8, threatens the voluntary boards in particular of the hospitals throughout the province of Ontario. It would diminish the role of the CEO, and this would ensure that hospital CEOs are directly accountable to their boards, and at least eliminate that cause of concern.

The Vice-Chair: Debate?

Shall PC motion subsection 21(5) carry? All in favour? Opposed? It's lost.

Shall section 21, as amended, carry? All in favour? Opposed? It's carried.

Section 21.1: Ms Wynne, please.

Ms Wynne: I move that section 21.1 of the bill be amended by adding the following subsection:

"Restriction

"(2.1) The minister shall not give a notice under subsection (1) that proposes to make directions in an order under subsection 26(1) unless,

"(a) a compliance directive has been issued in respect of the circumstance or a related circumstance that is referred to in the notice; or

"(b) the circumstance referred to in the notice relates to non-compliance with,

"(i) a compliance directive,

"(ii) an order made under subsection 26(1), or
 "(iii) an order made under subsection 26.1(5)."

So this clarifies that there has been a compliance directive before an order.

The Vice-Chair: Discussion? Debate?

Shall government motion subsection 21.1(2.1) carry?
 All in favour? Opposed? It's carried.

Shall section 21.1, as amended, carry? All in favour?
 Opposed? It's carried.

Section 22: Ms Wynne, please.

Ms Wynne: I move that paragraph 11 of subsection 22(3) of the bill be amended by striking out "subsection 29(3)" and substituting "subsection 29(2)."

The Vice-Chair: Debate?

Ms Wynne: Again, this is a correction of a mistake in cross-reference. So it's not substantive.

The Vice-Chair: Shall government motion subsection 22(3) carry? All in favour? Opposed? It's carried.

Shall section 22, as amended, carry? All in favour?
 Opposed? It's carried.

Section 25: Shall section 25 carry? Opposed? It's carried.

We're now on to section 26. Ms Wynne, please.

Ms Wynne: I gave people an amendment to subsection 26(1), on loose paper. I move that subsection 26(1) of the bill be amended by adding "and the minister proposed in the notice to issue an order under this section" after "notice was given by the minister."

Again, this was to make explicit the order of events in terms of issuing orders and notices of orders.

The Vice-Chair: Any debate?

Shall subsection 26(1) carry? All in favour? It's carried.

Ms Wynne, please.

Ms Wynne: I move that subsection 26(4) of the bill be amended by striking out "or chief executive officer."

This was a correction of a mistake in reference to CEOs, since orders can't be issued against CEOs.

The Vice-Chair: Debate?

Shall motion subsection 26(4) carry? Carried.

Ms Wynne, please.

1700

Ms Wynne: I move that section 26 of the bill be amended by adding the following subsection:

"No delegation

"(8) Despite subsection 3(3) of the Ministry of Health and Long-Term Care Act, the Minister shall not delegate the power to issue an order under subsection (1)."

There was a concern raised that it would be someone in the ministry who would be issuing this order, and this clarifies who can issue the order.

The Vice-Chair: Any discussion? Shall government motion subsection 26(8) carry? All in favour? It's carried.

Shall section 26, as amended, carry? All in favour?
 Carried.

Section 26.1: Ms Witmer, please, a recommendation.

Mrs Witmer: Yes, it's actually a recommendation. I just want to give notice that we are going to be voting

against this section. Obviously, we cannot support the punitive sanctions set out in this section and so we're going to be voting against it.

Ms Martel: I would vote against it as well. This is another section where it is very clear in the language of the bill in the provisions that in fact the minister does have the unilateral power to issue orders and directives. In this case, the order refers to holding back or reducing or varying compensation. The minister has said on numerous occasions that accountability agreements have to be negotiated. I've pointed out the sections previously where, if that were true, the language in the bill that allows for him to unilaterally issue orders and compliance directives would have been deleted.

In the same way, if these agreements were negotiated and we were working collaboratively together, there would not be provisions in the bill that essentially allow the minister to hold back, reduce or vary compensation provided to a chief executive officer in any manner or for any period of time as he is now allowed to do under subsection 26.1(6), page 32 of the bill.

I said earlier in the course of the public hearings—and I'll repeat it—that chief executive officers are not employees of the Ministry of Health; they are employees of that particular volunteer board. I suspect that the first time the government tries to implement this particular section, they will have a chief executive officer who will be making that very point in law.

But again, all of the references—the actual language or the text in the bill—that allow for the minister to do something unilaterally, whether it be to withhold money from a hospital board or, in this case, from the CEO, are references that should be removed and an independent third party should be dealing with those issues where there are disputes.

Mr McMeekin: It seems to me that on those rare occasions where there may be a failure to be collaborative and, particularly given the astute observation about ambiguity in law, the buck has to stop somewhere. It's not enough to just mouth words about accountability. There are provisions within the legislation to be collaborative around the agreements. There are provisions within the legislation to have those challenged judicially, if that's appropriate. But there also needs to be a provision somewhere in the bill that the buck stops here, and I think this provision does that.

The Vice-Chair: Further debate?

Shall section 26.1 carry? All in favour?

Ms Martel: Recorded vote.

Ayes

Brownell, Cansfield, Craitor, Fonseca, McMeekin,
 Wynne.

Nays

Martel, Witmer.

The Vice-Chair: It's carried.

Section 27: Your motion, Ms Witmer.

Mrs Witmer: Again, we would have to recommend voting against this section 27, based in large measure on that we simply cannot support the punitive sanctions that are in this bill. We really do not support the ability for the government to deal directly with CEOs. So we are very, very strongly opposed and we regret very much that this government has not sought a resolution, in particular with the Ontario Hospital Association, in making sure that the legislation addresses the concerns they have.

The Vice-Chair: Any discussion?

Ms Wynne: I think we've said it before, but the point of this bill is to establish a new relationship with those institutions and those providers. The accountability process that we've laid out is designed to re-jig that relationship, and the accountability agreements are designed to do that. I have a lot of optimism that we're not going to have to get to the point where this section would have to be used.

The Vice-Chair: Further discussion?

Shall section 27 carry?

Interjection: Recorded vote.

Ayes

Brownell, Cansfield, Craitor, Fonseca, McMeekin, Wynne.

Nays

Martel, Witmer.

The Vice-Chair: It's carried.

Section 28: Shall section 28 carry? All those in favour? Opposed? Carried.

Ms Wynne: I move that subsection 29(2) of the bill be amended by striking out "ordered" and substituting "required."

This is an issue of consistency in wording. Does everybody see where we are?

The Vice-Chair: Yes. Any discussion?

Shall government motion subsection 29(2) carry? Opposed? It's carried.

Shall section 29, as amended, carry? All in favour? Opposed? It's carried.

Shall section 30 carry? All in favour? Opposed? It's carried.

Shall section 31 carry? All in favour? Opposed? It's carried.

Shall section 32 carry? All in favour? Opposed? It's carried.

Section 32.1: Ms Wynne, please.

Ms Wynne: I move that subsection 32.1(11) of the bill be struck out and the following substituted:

"No review

"(11) Subject to subsection (12), a court shall not review any action, decision, failure to take action or failure to make a decision by the Lieutenant Governor in Council or the minister under this section.

"Exception

"(12) Any person resident in Ontario may make an application for judicial review under the Judicial Review Procedure Act on the ground that the minister has not taken a step required by this section.

"Time for application

"(13) No person shall make an application under subsection (12) with respect to a regulation later than 21 days after the day on which,

"(a) the minister publishes a notice with respect to the regulation under clause (1)(a) or subsection (9), where applicable; or

"(b) the regulation is filed, if it is a regulation described in subsection (10).

Again, this provides the opportunity for judicial review.

The Vice-Chair: Discussion?

Mr McMeekin: This importantly provides some of that much-requested balance that some members of the justice and social policy committee were looking for with earlier sections. I think it's a nice juxtaposition to some of the powers that were contained, that people had raised some alarms about, to in fact see this provision there.

The Vice-Chair: Further debate, discussion?

Shall government motion subsection 32.1(11) carry? In favour? Opposed? It's carried.

Shall section 32.1, as amended, carry? All in favour? Opposed? It's carried.

Section 32.2: Ms Witmer, the PC motion.

Mrs Witmer: I move that the bill, as amended by standing committee on justice and social policy before second reading, be amended by adding the following section:

"Faith-based mission

"(1) Nothing in this part authorizes the minister or the Lieutenant Governor in Council to interfere, directly or indirectly, with the faith-based aspects of a health resource provider that has a faith-based mission or governance structure.

"Same

"(2) The powers under this part shall be exercised in the manner that is consistent with the faith-based aspects of a health resource provider that has a faith-based mission or governance structure."

The reason we have brought this forward is that certainly there is some concern from faith-based health care providers in Ontario who see the implementation of section 3 of Bill 8 as a threat to their provision of health care and see the ability to jeopardize their contribution to the health of the communities they serve.

1710

I just want to quote from a letter that Premier McGuinty wrote to the Catholic Health Association of Ontario in August 2003:

"The Ontario Liberals recognize the invaluable contribution that the Catholic Health Association of Ontario ... and the caregivers you represent have made as partners in the delivery of quality health care in our province.

"As I have stated in the past, the Ontario Liberals are committed to preserving the Catholic health ministry in our province. We appreciate that governance issues are of the utmost importance if Catholic hospitals, long-term-care facilities and home care providers are to preserve their ministry."

If the government believes what is written, then I believe there should be no hesitation on their part in including the clause that I have just included in the legislation.

The Vice-Chair: Discussion?

Ms Wynne: There's no comparable provision related to faith-based institutions anywhere in health legislation. The reason I'm not supporting this motion is that to do so would suggest that there needs to be a special provision for all sorts of organizations, all sorts of different groups who have an interest in health provision. The context in which the accountability agreements will be negotiated is the context in which the faith-based organizations are delivering health care now, and that context remains the same.

Ms Martel: I'd like to ask counsel, when the Catholic Health Association was before us they referenced other provincial jurisdictions and language that appeared and gave us the sense that those were provisions that protected faith-based health care delivery. Can you tell us again why none of those provisions would work in this case?

Mr Maisey: It's Robert Maisey of the Ministry of Health and Long-Term Care. My recollection is that those two situations were in Alberta and Saskatchewan, where those governments had entered into some form of contractual agreement with a representative body in those provinces, and it was not legislation.

Ms Martel: What was the nature of the contractual agreement? I remember asking them a question that referred to delivery of health care services. At least I thought I remember asking them that, and they said yes. What was the nature of the agreement and why can't it be applied here?

Mr Maisey: That was an agreement between the government and an umbrella organization for delivery of health care services. It was not a legislative provision. A legislative provision obviously has a much higher legal form than a contractual provision, because a contract can be changed.

Ms Martel: The government could negotiate a contract with the Catholic Health Association as a representative body of those groups that deliver health care services, either long-term-care facilities or hospital-based?

Mr Maisey: That's right.

Ms Martel: If the government is adamant about not moving in a direction which would see section 32.2 added, as per the request that was made by the association to the committee in a letter dated May 27, what is the government prepared to do then by way of a similar contractual agreement with the Catholic Health Associ-

ation that would, through that mechanism, give them the protections that they're looking for? Is that a possibility?

Mr Maisey: I suppose it is. I'm afraid I can't answer the question as to what the government intends to do, because I'm not part of the Ministry of Health in working on that particular aspect. But I believe there was some discussion around potentially dealing with those concerns through the processes that are in place, either now or in the future, for negotiating these types of accountability agreements, such as through the joint planning and policy committee, or other processes.

Ms Martel: But even through that process, it would be individual hospitals working with the ministry, right? Not the association on behalf of.

Mr Maisey: Well, at the moment the JPPC is an Ontario Hospital Association and ministry process, so I suspect it would be possible to do it either through that process or through a different process with a faith-based organization or group of organizations.

Ms Martel: Mr Chair, may I just make the suggestion then? If the government was going to accept it, it would be here as a government amendment, so it's not. So I'm assuming that we're not going to be looking at this because the government feels there's not a mechanism to do it within individual accountability agreements.

I would then strongly recommend to the government that they look at the contractual agreements that exist in Saskatchewan and Alberta, to sort out whether or not there's an overarching contractual agreement that could be arrived at with the association and the representative hospitals and long-term care facilities that it speaks on behalf of to provide as similar a protection as we can. If it can't be by way of legislation, and clearly the government says it can't, then to give them some comfort that through the process of developing the accountability agreements, faith-based institutions will be protected. I make that suggestion to the government.

The Vice-Chair: Thanks, Ms Martel.

Mr McMeekin: This is a quandary for some of us, because on the one hand you want to respect the values and the historic nature and charter of those institutions, which in many cases were foundational in terms of providing health care. On the other hand, we dealt with a section earlier, section 20, which talked about timely and accessible services to all services under the Canada Health Act.

So I guess one of my questions would be, in particular recognizing the sensitivities here—and I don't want to trample on those, but on the other hand I want to ensure that those who show up in a publicly-funded health care facility at least have access. Alternatively, if a faith-based group finds itself in a position where they can't deliver a service, for whatever reason or combination of reasons, I don't think the amendment covers that off. So I don't want to see people denied access to timely and accessible services. I don't see any provision in the amendment to ensure that the very section we passed around timely and accessible services isn't thwarted, by definition, by including this.

I'm sensitive to the suggestion that was made—I think I heard it—that there will be agreements that will need to be worked out and, I'm assuming, with those provisions within those agreements to ensure some alternate access to services that might not be rendered in a faith-based hospital. To that, we've had the additional wisdom, as she is so wont to do, from Ms Martel, indicating that there are some other provincial jurisdictions that have struggled with this and come up with some useful alternative language.

On balance, having said all of that, I'm inclined not to support this, but with the clear understanding that we take Ms Martel up on her very good suggestion, if we can direct—certainly suggest, but I would say suggest and direct—the ministry to in fact investigate those provisions. Again, it's a leap of faith here—we're talking about faith-based—that's worked out fairly well historically in the province under the leadership of the previous health minister and others. I have no reason to believe that won't happen, but I guess the other part of it is I'm not sure I want to open a whole can of worms here either by putting something down too quickly, perhaps, that with a little bit more investigation, research and sensitive and deliberative consultation, we can resolve.

The Vice-Chair: When Mr McMeekin, when you were speaking, and Ms Martel, I noticed the ministry people were making some notes there, so I think the point has been taken and well understood.

1720

Mr Brownell: Basically, I'm just going to follow up with what Mr McMeekin said. I fully agree. Ms Martel brought an idea forward. I've struggled with this. I've expressed comments to Ms Wynne about this section and my struggles. I think if other provinces have something in place, let's investigate. Let's work at something that will assist these faith-based providers. I'm willing and ready to work together to try to get something in here.

Ms Wynne: Can I just say one more thing? Just be aware that you're not just talking about one group that wants to make sure that provision of care is protected for them. Francophone groups, multicultural groups, disability groups, sexual orientation—there are all sorts of groups that want to make sure that care is provided according to their needs. I have no problem with what Ms Martel has suggested, but I think we just need to be aware of what we're talking about.

The Vice-Chair: Further debate?

Shall the PC motion to insert new section 32.2 carry? All in favour? Opposed? It's lost.

Section 33: A government motion, Ms Wynne, please.

Ms Wynne: I move that the provisions of the Health Insurance Act set out in section 33 of the bill be amended by adding the following section:

“Transitional

“15.2(1) The following rules apply with respect to a physician or designated practitioner to whom subsection 9.1(7) of the Commitment to the Future of Medicare Act, 2004, applies:

“1. Sections 15 and 15.1 do not apply to him or her.

“2. Subsections 15(5), 16(5), 16.1(2), 17(2), 25(2) to (9), and 27.2(3) and (4), as applicable, as they existed immediately before their repeal by the Commitment to the Future of Medicare Act, 2004, continue to apply to the physician or designated practitioner, as the case may be, as if they had not been repealed, except in respect of any prescribed accounts or classes of accounts, and subject to any prescribed circumstances or conditions.

“3. Where, under subsection 27.2(3), the physician or designated practitioner is required to temporarily submit his or her accounts directly to the plan, the submission of the accounts is not a deemed election for the purposes of subsection 9.1(6) of the Commitment to the Future of Medicare Act, 2004, but subsection 9(2) of that act applies to him or her during the time that he or she is temporarily required to submit accounts directly to the plan.

“4. All other applicable provisions of this act apply to the physician or designated practitioner.

“Same

“(2) Where a physician or designated practitioner to whom section 9.1 of the Commitment to the Future of Medicare Act, 2004, applies submits his or her accounts for the rendering of insured services to insured persons directly to the plan, subsections 25(2) to (9) of this act, as they existed before their repeal, apply to him or her with respect to accounts submitted before he or she commenced submitting his or her accounts directly to the plan.

“Interpretation

“(3) In this section,

“‘physician’ and ‘designated practitioner’ means a physician or designated practitioner within the meaning of part II of the Commitment to the Future of Medicare Act, 2004.”

The Vice-Chair: Debate?

Shall the government motion on section 33 of the bill, section 15.2 of the Health Insurance Act, carry? All in favour? Opposed? It's carried.

Shall section 33, as amended, carry? All in favour? Opposed? It's carried.

I think we may be able to collapse the next few sections, with agreement of the committee. That would be sections 34, 35 and 36.

Shall sections 34, 35 and 36 carry? Opposed? They're carried.

We're now dealing with section 37.

Ms Wynne: I have an amendment to subsection 37(1) that I passed out to people.

I move that subsection 37(1) of the bill be struck out and the following substituted:

“Same

“(1) Subsection 25(2) of the act, as amended by the Statutes of Ontario, 2002, chapter 18, schedule I, section 8, is repealed.”

I may have to get legal counsel to speak to this one.

The Vice-Chair: Ms Wilson.

Ms Wilson: Yes. This is a provision right now in the bill, which is a transitional provision. It was put in to deal

with physicians' accounts, where the physician was opt-in but they were previously opt-out, so certain provisions of the Health Insurance Act would still apply when there was arguing of their opt-out accounts. With the new provisions respecting opt-out, we've moved that provision over there and we just forgot to repeal that. So it's already included in the new 15.2 under section 33.

The Vice-Chair: Debate?

Shall government amendment subsection 37(1) carry? Carried.

Shall section 37, as amended, carry?

With committee's concurrence, I think we can then collapse sections 38, 39, 40 and 41. Can we move that those sections carry? Opposed? They're all carried.

Section 42: Ms Wynne, please.

Ms Wynne: I move that section 42 of the bill be struck out and the following substituted:

"Commencement

"42(1) Subject to subsections (2) and (3), this act comes into force on the day it receives royal assent.

"Same

"(2) Sections 1 to 6, 7 to 18 and 33 to 41 come into force on a day to be named by proclamation of the Lieutenant Governor.

"Same

(3) Section 26.1 comes into force two years after this act receives royal assent."

This is a two-year delay on the remedy for the action of CEOs.

The Vice-Chair: Debate?

Shall government motion section 42 carry? Sorry, Mr McMeekin.

Mr McMeekin: I was just going to say, another example of more reasonable balance and openness to being deliberative and collaborative.

Ms Martel: The souls of flexibility.

Mr McMeekin: Yes.

The Vice-Chair: Thank you, Mr McMeekin.

Shall the government motion on section 42 carry? Opposed? It's carried.

Shall section 42, as amended, carry? Carried.

Shall section 43 carry? Carried.

Ms Wynne: Mr Chair, could I request a very short recess?

The Vice-Chair: You sure can.

Ms Wynne: OK. Five minutes?

The Vice-Chair: Five minutes would be great. All in favour? It's carried.

Ms Wynne: Thank you.

The committee recessed from 1728 to 1740.

The Vice-Chair: We're now dealing with the preamble to the bill. The first motion here is a government motion dealing with paragraph 5 of the preamble.

Ms Wynne: I move that paragraphs 5 and 6 of the preamble to the bill be struck out and the following substituted:

"Recognize that pharmacare for catastrophic drug costs is important to the future of the health system;

"Recognize that access to community-based health care, including primary health care, home care based on assessed need and community mental health care are cornerstones of an effective health care system."

We're introducing this motion because it's consistent with the rest of the language in the bill and it doesn't introduce a new concept in terms of what the bill is about. That's why we're supporting this motion.

The Vice-Chair: I appreciate that, Ms Wynne. I think there's opinion from two experts in parliamentary procedure. I'll just read this to you. It says:

"In the case of a bill that has been referred to a committee after second reading, a substantive amendment to the preamble is admissible only if it is rendered necessary by the amendments made to the bill. In addition, an amendment to the preamble is in order when the purpose is to clarify it...."

That citation came from Marleau and Montpetit, who are experts and read in the rules of parliamentary procedure.

As there have been no amendments to the bill that render the proposed amendments to the preamble necessary, I find the amendments to the preamble out of order at this time. But if there is unanimous consent of the committee, we can accept the amendments.

Ms Martel: I'm going to make a suggestion then, because we have two proposals before us. We have the government amendment, which I support, and the amendment from Mrs Witmer, which I also support. I would hope that we can get consent to agree to both. Then I would give unanimous consent. So maybe we can have a discussion. If you're amenable to having both, then I would give unanimous consent for both to be passed.

Ms Wynne: I'd like to ask a question of legal counsel. My understanding is that the Conservative amendment, the introduction of the promotion of health, is different than or inconsistent with what we've talked about before, the rest of the language in the bill. Can you just tell me the implications, if any, of introducing that concept into the preamble? If there are no implications, then that's fine.

Ms Wilson: I don't see any legal implications. The purpose of the preamble is not to create any new rights, so the wording of this looks fine.

Mrs Witmer: I would certainly be prepared to give unanimous consent to both the government motion and, obviously, the one that I've introduced, which does focus on and, I believe, recognizes mental health as a very integral component of the health care system.

Mrs Donna H. Cansfield (Etobicoke Centre): Just a clarification. Given the comments that you've just made previous about the inadmissibility of additional preamble because it wasn't part of the original bill, would that not follow suit with this as well? Would you not have to have—

The Vice-Chair: Unanimous consent for the PC amendment?

Mrs Cansfield: Right. Or would it be otherwise, that it would have to be unanimous consent?

The Vice-Chair: Correct. Any further discussion?

First of all then, I would ask unanimous consent for the government amendment to the preamble. Is there unanimous consent? Agreed.

All in favour that the preamble carries? Agreed. So it's carried.

The PC motion: unanimous consent? Sorry, do you want to move it, Mrs Witmer? I'm just a little ahead of myself.

Mrs Witmer: I move that the preamble to the bill, as amended by the standing committee on justice and social policy before second reading, be amended by adding the following paragraph after paragraph 7:

"Recognize that the promotion of health and the prevention and treatment of disease includes mental and physical illness."

The Vice-Chair: Is there unanimous consent that we carry that? Carried.

Shall the preamble, as amended, carry? All in favour? Carried.

Shall the long title of the bill carry? All in favour? Opposed? It's carried.

Shall Bill 8, as amended, carry?

Ms Martel: I disagree, so I'd like a recorded vote.

Ayes

Brownell, Cansfield, Craitor, Fonseca, McMeekin, Wynne.

Nays

Martel, Witmer.

The Vice-Chair: It's carried.

Shall I report the bill, as amended, to the House? Opposed? It's carried.

Thanks very much for the co-operation of the committee. I appreciate it.

The committee adjourned at 1747.

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